LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

April 11, 2022

Certified Mail Receipt Number: 70192280000105040170

Mr. Justin Headlee-Borden
Ms. Carol Vanairsdale
GeoVera Specialty Insurance Company
1455 Oliver Road
Fairfield, CA 94534

Re: Examination of GeoVera Specialty Insurance Company (NAIC #10182) as of June 30, 2021

Dear Mr. Headliee-Borden and Ms. Vanairsdale:

Please find enclosed a copy of the above referenced examination report which has been adopted by the Louisiana Department of Insurance.

The report must be submitted to all Directors of the Company and each must sign the enclosed affidavit stating that they have received a copy of the report. The executed forms must be returned to this office within thirty (30) days of delivery of this letter as certified by return receipt. Please send these forms to the attention of Lisa Fullington. Failure to comply may result in regulatory action.

This report is now open for public inspection. You have a right to demand a hearing pursuant to La. R.S. 22:2191 within thirty (30) days of your receipt of this letter and report.

If you have any questions, please call Lisa Fullington, at (225) 219-5159.

Sincerely,

Jeffrey Zewe
Deputy Commissioner
Office of Consumer Services

JWZ/jg
Enclosures

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900 • FAX (225) 342-3078
https://www.ldi.la.gov

DATE: _____

Honorable James J. Donelon
Commissioner of Insurance
Baton Rouge, Louisiana

This is to certify that I, _____, the undersigned
(Please Print Name)

Director of GeoVera Specialty Insurance Company have received and read the report of examination and related directives of said Company as of June 30, 2021, completed by a representative of the Commissioner of Insurance.

_____

Director

LOUISIANA DEPARTMENT OF INSURANCE

Report of the

TARGETED MARKET CONDUCT EXAMINATION

OF

GeoVera Specialty Insurance Company
NAIC Company Code 10182

1455 Oliver Road
Fairfield, CA 94534

For the Examination Period
August 27, 2020 through June 30, 2021

EXAMINATION REPORT PREPARED BY
INDEPENDENT CONTRACTORS FOR
THE LOUISIANA DEPARTMENT OF INSURANCE

April 1, 2022

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SALUTATION

April 1, 2022

Honorable James J. Donelon
Insurance Commissioner
State of Louisiana
P.O. Box 94214
Baton Rouge, LA 70804-9214

Commissioner Donelon:

Pursuant to your instructions and in compliance with the provisions of La. R.S. 22:1967 and La. R.S. 22:1981, et seq., a market conduct examination has been conducted of:

GeoVera Specialty Insurance Company
NAIC Company Code 10182

1455 Oliver Road
Fairfield, CA 94534

The report thereon, as of June 30, 2021, is herein respectfully submitted.

Scope of the Examination

The Louisiana Department of Insurance (the LDI or the Department) conducted a targeted Market Conduct Examination (Examination) of GeoVera Specialty Insurance Company (GSIC or Company). The scope of the examination is limited to claims arising as a result of Hurricanes Laura, Delta, and Zeta and includes analyses of the Company's complaint and claims handling processes specifically for the homeowners lines of business. The Examination covered the period August 27, 2020, through June 30, 2021 (Examination Period).

The Examination commenced on July 1, 2021 and was called pursuant to La. R.S. 22:1967 and La. R.S. 22:1981, et seq. The Department retained Risk & Regulatory Consulting, LLC (RRC or Examiners) to assist the Department with the Examination.

This Report of Examination (Report) reflects the Louisiana insurance activities of the Company. The Examination was conducted under the direction and overall management and control of representatives of the LDI.

The Report is a report by exception. All unacceptable or non-compliant practices may not have been identified. The failure to identify specific non-compliant Company practices does not constitute acceptance of these practices.

RRC personnel participated in this Examination in their capacity as Market Conduct Examiners. RRC provides no representations regarding questions of legal interpretation or opinion. The determination of violations or potential violations (Finding) is the sole responsibility of the LDI. All statutory citations or any other legal interpretations included herein were confirmed by the LDI for inclusion in this Report. In reviewing materials for this Report, the Examiners relied upon records provided by the Company.

Company Profile

GSIC was incorporated on November 28, 1994. The Company was formed as a California domiciled company as part of the United States Fidelity and Guaranty Company group of companies. The St. Paul Companies, Inc. (St. Paul) acquired USF&G in November of 1998. In April 2004, the St. Paul merged with Travelers Insurance. In August 2005, GSIC was acquired by GeoVera Holdings, Inc. On August 2, 2005, an agreement was signed to sell the Company and its affiliates to Freidman Fleischer & Lowe and Hellman & Friedman (US) Holdings. On August 8, 2012, the Company and its affiliates were acquired by Flexpoint Ford, a private equity firm specializing in financial services and healthcare sectors. On May 20, 2013, GSIC redomesticated from California to Delaware.

GSIC offers residential wind and homeowners coverage to homeowners along the coastal areas of Alabama, Florida, Louisiana, South Carolina, North Carolina, and Texas. GSIC's products are wind only and multi-peril policies covering property and liability losses for homeowners, renters and condominium owners, and cover losses to the home and its contents, and insure against personal liability claims and provide for reimbursement of certain medical expenses.

The Company is licensed to write property and casualty business in two states, California and Delaware and is eligible to write surplus lines in the remaining 48 states. GSIC has a surplus line license in Louisiana since February 25, 2005. Net admitted assets as of September 30, 2021, were approximately $192.9 million, with policyholders' surplus of approximately $19.0 million. The Company has a current AM Best financial strength rating of A. The Company's ultimate parent is GeoVera Investment Group, Ltd.

As of December 31, 2020, the Company's direct earned premiums in Louisiana totaled approximately $60.7 million, with homeowners insurance comprising approximately $35.5 million of the total.

LOUISIANA HOMEOWNERS DIRECT PREMIUM WRITTEN AND EARNED [1]

Year	All Lines Direct Premium Written	All Lines Direct Premium Earned	Line 4 Homeowners Direct Premium Written	Line 4 Homeowners Direct Premium Earned
First Six Months of 2021 through June 30, 2021	$25,724,534	Not Available	Not Available	Not Available
2020	$59,178,014	$60,679,844	$33,675,411	$35,532,240

[1] Sources: SNL Financial, GSIC Annual Statement, and Second Quarter Schedule T

Examiners' Methodology

The Examination is based upon standards and testing approved by the LDI. The Examiners' work plan was developed based upon a targeted examination approach as determined by the LDI and relevant Louisiana insurance laws. The NAIC Market Regulation Handbook (Handbook) served as guidance and the basis for the procedures performed, modified to meet the specific needs of the LDI and consider Louisiana laws. Examination testing procedures were performed following the review of preliminary data requests, interviews with management, and consultation with the LDI.

During the course of the Examination, the Examiners selected and tested samples related to the scope of the Examination. Specifically, the Examination focused on a review of the following practices and procedures:

1. Complaint Handling
2. Claims Handling
    a. Closed with payment claims
    b. Closed without payment claims

The Examiners accomplished a review of these areas through the interviews with senior Company managers and officers, who explained the Company's operations, and through the examination of the Company's policies and procedures, and random sample testing of complaints and claim files.

The Report is focused on improper practices by the Company, which resulted in non-compliance with Louisiana laws. Criticisms were prepared and communicated to the Company addressing potential violations identified during the Examination. Violations and areas of non-compliance are cited in this Report as a Finding. All Findings have been approved by the LDI prior to submitting them to the Company for their review and response.

The Examiners recommended a sampling methodology and approach which included random sample selections specific to the scope areas under review. Galvanize was used to select each random sample. Each sampling methodology and approach was approved by the LDI.

Complaint Handling

The Examiners submitted IDRs (Information and Data Requests) during the Examination, for which the Company provided responses. Interviews were conducted with the Company's management and operational personnel knowledgeable of the Company's complaint handling processes and procedures. The Examiners used the information from these sources to determine whether complaint handling procedures were adequate. A random sample was selected from the Company's complaint logs, which were provided for the Examination Period to test for compliance with specific Louisiana laws.

The complaints selected were reviewed to determine whether complaint files were handled in accordance with Louisiana laws and the Company's complaint handling procedures and whether there was sufficient documentation to show the Company addressed all aspects of the complaint. The Examiners also tested the complaint samples to determine whether the Company's responses to the LDI were timely, complete, and

accurate. In addition, the Examiners reviewed claims associated with each complaint sample to determine whether the Company's claim disposition was reasonable and whether the disposition was changed as a result of the complaint. The Examiners' testing of the associated claims included determining when satisfactory proof of claim was submitted to the Company. The Examiners considered satisfactory proof of loss when the Company received sufficient information from the insured and/or inspections were completed indicating a payment was owed.

Claims Handling

The Examiners submitted IDRs throughout the course of the Examination, for which the Company provided responses. Interviews were conducted with the Company's claim management and operational personnel knowledgeable of the Company's claim handling processes, practices, and procedures.

The Examiners selected and tested random samples of claims closed with payment and claims closed without payment during the Examination Period. The claims selected were reviewed to determine whether the claim files were handled in accordance with Louisiana laws, the Company's claim handling procedures and whether there was sufficient documentation to show the Company handled the claim correctly. The Examiners' testing of the sampled claims included determining when satisfactory proof of claim was submitted to the Company. The Examiners considered satisfactory proof of loss when the Company received sufficient information from the insured and/or inspections were completed indicating a payment was owed.

Examination Executive Summary

The following is a summary intended to provide a high-level overview of the results of the Examination and all substantive issues identified. The details regarding the scope of the Examination, the testing performed, and the Findings from the Examination are discussed further within this Report.

Specific populations, sample sizes, number of errors, and error rates for the scope areas tested are summarized in a table in the Examination Summary section of this Report. Detailed discussion of each Finding, including relevant laws, is included in the Factual Findings section of this Report.

The Examination disclosed the following Findings:

Complaint Handling

Finding #1 (Crit #1)
The Company was deemed to be in violation of Louisiana R.S. 22:1973. In three of the 48 complaints or 6.3% of the sample, a claim associated with the complaint was not paid the claim amount due within 60 days after satisfactory proof of loss was submitted. The Company agreed with this Finding.

Finding #2 (Crit #1)
The Company was deemed to be in violation of Louisiana R.S. 22:1892. In three of the 48 complaints or 6.3% of the sample, a claim associated with the complaint was not paid the claim amount due within 30 days after satisfactory proof of loss was submitted. The Company agreed with this Finding.

Claims Handling

Finding #1 (Crit #2)
The Company was deemed to be in violation of Louisiana R.S. 22:1973. In one of 26 claims with payment during the Examination Period, or 3.9% of the sample, the Company failed to make a payment within 60 days after satisfactory proof of loss was submitted. The Company agreed with the Finding.

Finding #2 (Crit #2)
The Company was deemed to be in violation of Louisiana R.S. 22:1892. In two of 26 claims with payment during the Examination Period, or 7.7% of the sample, the Company failed to make a payment within 30 days after satisfactory proof of loss was submitted. The Company agreed with the Finding.

Finding #3 (Crit #3)
The Company was deemed to be in violation of Louisiana R.S. 22: 1964(14)(b), (c) and (f). In six of 26 claims with payment during the Examination Period, or 23.1% of the sample, the Company's utilization of multiple desk adjusters delayed the claim investigation and settlement of the claim. The Company disagreed with the Finding.

Finding #4 (Crit #4)
The Company was deemed to be in violation of Louisiana R.S. 22:1990. In 23 of 35 claims without payment during the Examination Period, or 65.7% of the sample, the Company did not maintain complete and accurate records and/or did not provide records/documentation. The Company disagreed with the Finding.

Finding #5 (Crit #4)
The Company was deemed to be in violation of Louisiana R.S. 22:1990. In 1 of 26 claims with payment during the Examination Period, or 3.9% of the sample, the Company did not maintain complete and accurate records and/or did not provide records/documentation. The Company disagreed with the Finding.

Finding #6 (Crit #4)
The Company was deemed to be in violation of Louisiana R.S. 22:1984. In 23 of 35 claims without payment during the Examination Period, or 65.7% of the sample, the Company did not maintain complete and accurate records and/or did not provide records/documentation. The Company disagreed with the Finding.

Finding #7 (Crit #4)
The Company was deemed to be in violation of Louisiana R.S. 22:1984. In 1 of 26 claims with payment during the Examination Period, or 3.9% of the sample, the Company did not maintain complete and accurate records and/or did not provide records/documentation. The Company disagreed with the Finding.

Examination Factual Findings

Complaint Handling

Finding #1 – Failure to Pay Claim Timely (Crit #1 – Company Agreed)
The Examiners selected a random sample of 48 complaints for review and found in three of the 48 sample complaints, or 6.3% of the sample, a claim associated with the complaint was not paid the claim amount due within 60 days after satisfactory proof of loss was submitted. The three claims were paid 62, 68 and 75 days after satisfactory proof of loss was submitted to the Company. The Company agreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1973
Good faith duty; claims settlement practices; cause of action; penalties

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.
B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A of this Section:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to pay a settlement within thirty days after an agreement is reduced to writing.

(3) Denying coverage or attempting to settle a claim on the basis of an application which the insurer knows was altered without notice to, or knowledge or consent of, the insured.

(4) Misleading a claimant as to the applicable prescriptive period.

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

(6) Failing to pay claims pursuant to R.S. 22:1893 when such failure is arbitrary, capricious, or without probable cause.

Finding #2 – Failure to Pay Claim Timely (Crit #1 – Company Agreed)
The Examiners selected a random sample of 48 complaints for review and found in three of the 48 sample complaints, or 6.3% of the sample, a claim associated with the complaint was not paid the claim amount due within 30 days after satisfactory proof of loss was submitted. The three claims were paid 62, 68 and 75 days after satisfactory proof of loss was submitted to the Company. The Company agreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1892
Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; extension of time to respond to claims during emergency or disaster; penalties; arson-related claims suspension

A. (1) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, 1821, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest. The insurer shall notify the insurance producer of record of all such payments for property damage claims made in accordance with this Paragraph.

(2) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, R.S. 22:1821, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

(3) Except in the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim and of a claim for reasonable medical expenses within fourteen days after notification of loss by the claimant. In the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim within thirty days after notification of loss by the claimant except that the commissioner may promulgate a rule for extending the time period for initiating a loss adjustment for damages arising from a presidentially declared emergency or disaster or a gubernatorially declared emergency or disaster up to an additional thirty days. Thereafter, only one additional extension of the period of time for initiating a loss adjustment may be allowed and must be approved by the Senate Committee on Insurance and the House Committee on Insurance, voting separately. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in R.S. 22:1973.

(4) All insurers shall make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim.

B. (1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefor or failure to make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim, as provided in Paragraphs (A)(1) and (4) of this Section, respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2) of this Section when such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of fifty percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, or in the event a partial payment or tender has been made, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as reasonable attorney fees and costs. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

Claims Handling

Finding #1 – Failure to Pay Claims Timely (Crit #2 – Company Agreed)
The Examiners selected a random sample of 26 claims with payment for review and found in one of the 26 sample claims with payment, or 3.9% of the sample, the Company failed to make a payment due within 60 days after satisfactory proof of loss was submitted. The claim was paid 63 days after satisfactory proof of loss was submitted to the Company. The Company agreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1973
Good faith duty; claims settlement practices; cause of action; penalties

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A of this Section:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to pay a settlement within thirty days after an agreement is reduced to writing.

(3) Denying coverage or attempting to settle a claim on the basis of an application which the insurer knows was altered without notice to, or knowledge or consent of, the insured.

(4) Misleading a claimant as to the applicable prescriptive period.

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

(6) Failing to pay claims pursuant to R.S. 22:1893 when such failure is arbitrary, capricious, or without probable cause.

Finding #2 – Failure to Pay Claims Timely (Crit #2 – Company Agreed)
The Examiners selected a random sample of 26 claims with payment for review and found in two of the 26 sample claims with payment, or 7.7% of the sample, the Company failed to make a payment within 30 days after satisfactory proof of loss was submitted. The two claims were paid 34 and 63 days after satisfactory proof of loss was submitted to the Company. The Company agreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1892
Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; extension of time to respond to claims during emergency or disaster; penalties; arson-related claims suspension

A. (1) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, 1821, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest. The insurer shall notify the insurance producer of record of all such payments for property damage claims made in accordance with this Paragraph.

(2) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, R.S. 22:1821, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

(3) Except in the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim and of a claim for reasonable medical expenses within fourteen days after notification of loss by the claimant. In the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim within thirty days after notification of loss by the claimant except that the commissioner may promulgate a rule for extending the time period for initiating a loss adjustment for damages arising from a presidentially declared emergency or disaster or a gubernatorially declared emergency or disaster up to an additional thirty days. Thereafter, only one additional extension of the period of time for initiating a loss adjustment may be allowed and must be approved by the Senate Committee on Insurance and the House Committee on Insurance, voting separately. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in R.S. 22:1973.

(4) All insurers shall make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim.

B. (1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefor or failure to make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim, as provided in Paragraphs (A)(1) and (4) of this Section, respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2) of this Section when such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of fifty percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, or in the event a partial payment or tender has been made, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as reasonable attorney fees and costs. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

Finding #3 – Untimely Claim Payment (Crit #3 – Company Disagreed)

The Examiners selected a random sample of 26 claims with payment for review and found in six of the 26 sample claims with payment, or 23.1% of the sample, the Company's utilization of multiple desk adjusters delayed the claim investigation and settlement of the claims. A baseline of three or more desk and/or field adjusters during the claim processing period were evaluated. Of the six claims identified with three or more desk and/or field adjusters, one claim had three desk adjusters, three claims had four desk adjusters and two claims had five desk adjusters. As a result of having multiple adjusters, the Company had notable time delays and/or mishandling of the associated claim. Some of the issues identified as a result of having

multiple adjusters included: 1) failure to return calls; 2) claim closed when not applicable; 3) failure to initiate or complete follow-up for an initial field inspection report or reinspection report; 4) delays in seeking or acting upon management authority; 5) no activity in the file for up to a month with no explanation. When a claim is reassigned multiple times, each new adjuster must become familiar with the claim to determine what has been done, what has not been done, what needs to be done, and the need to make contact with the insured, resulting in the issues identified above. Each of the six claims identified were open more than six months. In addition, the Company's files for each of the six claim samples did not explain why multiple desk and/or field adjusters were used during the claim processing period. The Company disagreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1964
Methods, acts, and practices which are defined herein as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(14) Unfair claims settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(b) Failing to acknowledge and act reasonable promptly upon communications with respect to claims arising under insurance policies

(c) Failing to adopt and implement reasonable standards for the prompt investigations of claims arising under insurance policies

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

Finding #4 – Failure to Make Records Freely Accessible (Crit #4 – Company Disagreed)
The Examiners tested the entire population of 35 claims arising as a result of Hurricanes Laura, Delta, and Zeta and found in 23 of the 35 claims without payment, or 65.7% of the population, the Company did not produce and make freely accessible to the commissioner of insurance the accounts, records, documents, and files in its possession or control relating to the subject of the examination. After the Examiners requested the 35 claim files the Company informed the Examiners that 23 files could not be provided because they were litigated files. After the Examiners submitted a written request to the Company for additional information about the litigated claims and the Examiners participated in a meeting with the Company, the Company provided a written response indicating that the claims were not litigated claims and were subsequently identified as claims that were paid indemnity payments on an underlying claim file. The time between the initial request by the Examiners and when the Company provided the final response was 60 days. The Company disagreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1990
Production of books and records

Every insurer being examined, its officers, employees and representatives, shall produce and make freely accessible to the commissioner of insurance the accounts, records, documents and files in its possession or control relating to the subject of the examination, and shall otherwise facilitate the examination

Finding #5 – Failure to Make Records Freely Accessible (Crit #4 – Company Disagreed)
The Examiners selected a random sample of 26 claims with payment for review and found in one of the 26 sample claims with payment, or 3.9% of the sample, the Company did not produce and make freely accessible to the commissioner of insurance the accounts, records, documents, and files in its possession or control relating to the subject of the examination. After the Examiners requested the 26 claim files the Company informed the Examiners that the file could not be provided because it was a litigated file. Upon receiving this information from the Company, the Examiners requested a meeting to discuss the matter. Following the meeting the Company provided a written response indicating that the claim was not litigated but was only represented by an attorney. While the claim file was ultimately provided by the Company, the time between the initial request by the Examiners and when the Company provided the claim file was 46 days. The Company disagreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1990
Production of books and records

Every insurer being examined, its officers, employees and representatives, shall produce and make freely accessible to the commissioner of insurance the accounts, records, documents and files in its possession or control relating to the subject of the examination, and shall otherwise facilitate the examination

Finding #6 – Failure to Make Records Freely Accessible (Crit #4 – Company Disagreed)
The Examiners tested the entire population of 35 claims arising as a result of Hurricanes Laura, Delta, and Zeta and found in 23 of the 35 claims without payment, or 65.7% of the population, the Company did not produce and make freely accessible to the commissioner of insurance the accounts, records, documents, and files in its possession or control relating to the subject of the examination. After the Examiners requested the 35 claim files the Company informed the Examiners that 23 files could not be provided because they were litigated files. After the Examiners submitted a written request to the Company for additional information about the litigated claims and the Examiners participated in a meeting with the Company, the Company provided a written response indicating that the claims were not litigated claims and were subsequently identified as claims that were paid indemnity payments on the underlying claim file. The time between the initial request by the Examiners and when the Company provided the final response was 60 days. The Company disagreed with the Finding and was deemed to be in violation of the following Louisiana statute:

R.S. 22:1984
Commissioner of insurance to conduct financial and market analysis of insurers and regulated entities

C. Failure by an insurer or regulated entity to supply information requested by the Department of Insurance during the course of financial or market analysis may subject the insurer or regulated entity to revocation or suspension of its license, or, in lieu thereof, a fine not to exceed ten thousand dollars per occurrence. Every insurer or regulated entity shall produce and make freely accessible to the commissioner of insurance the accounts, records, documents, and files in its possession or control.

Finding #7 – Failure to Make Records Freely Accessible (Crit #4 – Company Disagreed)
The Examiners selected a random sample of 26 claims with payment for review and found in one of the 26 sample claims with payment, or 3.9% of the sample, the Company did not produce and make freely accessible to the commissioner of insurance the accounts, records, documents, and files in its possession or control relating to the subject of the examination. After the Examiners requested the 26 claim files the Company informed the Examiners that the file could not be provided because it was a litigated file. Upon receiving this information from the Company, the Examiners requested a meeting to discuss the matter. Following the meeting the Company provided a written response indicating that the claim was not litigated but was only represented by an attorney. While the claim file was ultimately provided by the Company, the time between the initial request by the Examiners and when the Company provided the claim file was 46 days. The Company disagreed with the Finding and was deemed to be in violation of the following Louisiana statute:

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Examination Summary

Summary of Examination Findings by Scope Area

Complaints

Finding	Description of Finding	Population	Sample Size	Number of Errors	Error Rate	Applicable Louisiana Statutes
Finding #1 Failure to Pay Claims Timely (Crit 1)	Not paying the claim amount due within 60 days after satisfactory proof of loss	119	48	3	6.3%	22:1973
Finding #2 Failure to Pay Claims Timely (Crit 1)	Not paying a claim within 30 days after satisfactory proof of loss	119	48	3	6.3%	22:1892

Claims

Finding	Description of Finding	Population	Sample Size	Number of Errors	Error Rate	Applicable Louisiana Statute
Finding #1 Failure to Pay Claims Timely (Crit 2)	Claims with Payment: Not paying the claim amount due within 60 days after satisfactory proof of loss	4,820	26	1	3.9%	22:1973
Finding #2 Failure to Pay Claims Timely (Crit 2)	Claims with Payment: Not paying a claim within 30 days after satisfactory proof of loss	4,820	26	2	7.7%	22:1892
Finding #3 Unfair claims settlement practices (Crit 3)	Claims with Payment: Utilization of multiple desk adjusters delayed the claim investigation and settlement of the claim	4,820	26	6	23.1%	22:1964(14) (b), (c) and (f)

Finding	Description of Finding	Population	Sample Size	Number of Errors	Error Rate	Applicable Louisiana Statute
Finding #4 Failure to Maintain and/or Produce Records, Documents and Files (Crit 4)	Claims without Payment: Failure to Make Records Freely Accessible	35	35	23	65.7%	22:1990
Finding #5 Failure to Maintain and/or Produce Records, Documents and Files (Crit 4)	Claims with Payment: Failure to Make Records Freely Accessible	4,820	26	1	3.9%	22:1990
Finding #6 Failure to Maintain and/or Produce Records, Documents and Files (Crit 4)	Claims without Payment: Failure to Make Records Freely Accessible	35	35	23	65.7%	22:1984
Finding #7 Failure to Maintain and/or Produce Records, Documents and Files (Crit 4)	Claims with Payment: Failure to Make Records Freely Accessible	4,820	26	1	3.9%	22:1984

Examiners' Recommendations

The Examination Findings identified above relate to Findings with regard to the Company's policies, procedures, and practices related to complaint handling and claim handling, which constitute violations of applicable Louisiana laws. As such, the following are recommendations for the Company to consider, in working with the LDI, to address the violations noted and to mitigate future reoccurrence of the specific matters:

1. The Company should develop a written Corrective Action Plan (Plan), to be submitted to the LDI, within 30 days of receipt of the final report. The Plan should provide detailed steps the Company will take to correct the Findings and enhance future compliance with the referenced Louisiana laws, including a timeline for completion.

2. Upon completion of each remediation step in the agreed upon Plan, the Company shall provide a signed affidavit from an officer of the Company attesting to the completion of each corrective action step.

ACKNOWLEDGMENT

An examination has been conducted of the market conduct affairs of GeoVera Specialty Insurance Company as of June 30, 2021. This Examination was conducted in accordance with the Louisiana Department of Insurance guidelines and relevant Handbook procedures in the areas of complaint handling and claim handling.

The Examiners wish to express appreciation for the courteous cooperation and assistance given by the officers and employees of the Company during the course of this examination

Sincerely,

Robert W McManus, CIE, MCM
Examiner-In-Charge
Risk & Regulatory Consulting, LLC

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

ORDER ADOPTING REPORT OF EXAMINATION

OF

GeoVera Specialty Insurance Company

AS OF

June 30, 2021

Examiners of the Louisiana Department of Insurance completed the above Report.

The findings and conclusions of the Department regarding the status of the Company result from consideration of the review of the Report, relevant examiner work papers, and any written submissions or rebuttals of the Company.

IT IS HEREBY ORDERED that the examination report be accepted, adopted, and filed as an official record of the Department.

James J. Donelon
Commissioner of Insurance
State of Louisiana

BY: _____
Jeffrey Zewe
Deputy Commissioner
Office of Consumer Services
LA Department of Insurance

Dated this 11th day of April, 2022