REPORT OF TARGET MARKET EXAMINATION

OF

GEICO GENERAL INSURANCE COMPANY

NAIC # 35882

AS OF

DECEMBER 31, 2006

TABLE OF CONTENTS

SALUTATION.....i

AFFIDAVIT.....ii

FOREWORD.....1

SCOPE AND METHODOLOGY.....1

EXECUTIVE SUMMARY.....2

FACTUAL FINDINGS.....3

- CLAIM STANDARD 3.....3
- CLAIM STANDARD 5.....5
- CLAIM STANDARD 10.....6

SUMMARY OF STANDARDS.....7

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

GEICO GENERAL INSURANCE COMPANY

NAIC # 35882

The above examination was conducted by William P. Hobert, Examiner-in-Charge, and Market Examiner Robert De Berge.

The examination covered the period of January 1, 2006 through December 31, 2006.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Paul J. Hogan, FLMI, ALHC, CI, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

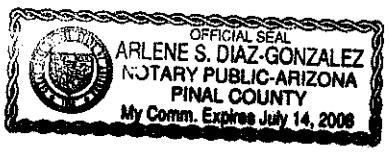
I, William P. Hobert, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Examiner Robert DeBerge, the Examination of GEICO General Insurance Company, hereinafter referred to as the "Company" was performed at the Company's offices at 930 North Finance Center Drive, Tucson, AZ 85710-1342. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management, as the Examination Report was not finalized. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and that any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

William P. Hobert, CPCU, CLU, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 24 day of January, 2008.

Notary Public

My Commission Expires July 14, 2008



FOREWORD

This targeted market examination of GEICO General Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this Report, including all work products developed in the production of this Report, are the sole property of the Department.

This examination consisted of a review of the Company's Private Passenger Automobile claim settlement practices. Examiners reviewed Private Passenger Automobile claim files to determine whether the Company was using claim methods and practices for acknowledging, investigating, settling and subrogating claims that were nondiscriminatory, equitable, thorough and compliant with policy provisions, state statutes and rules. Claim records were examined to determine if the objectivity and consistency of Company staff and practices in negotiating settlement amounts were reasonable and compliant.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director. Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

This examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. This target market examination of the Company covered the period from January 1, 2006 through December 31, 2006 for the business reviewed. The purpose of the examination was to determine compliance with A.R.S. §§ 20-268, 20-461, 20-462, 20-463, 20-466, 20-466.03, 20-468, 20-469, 20-2106 and A.A.C R20-6-801.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") on those policies, claims and complaints not in apparent compliance with Arizona law. The Finding forms were submitted for review and comment to the Company representative designated by Company management to be knowledgeable about the files. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action.

The examiners utilized both examination by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed without the need to utilize computer software.

File sampling was based on a review of underwriting and claim files that were systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, Cinda Smith, Senior Counsel. Samples are tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data will result in an exception ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally less than 5%, the standard will be considered as "met." The standard in the areas of procedures, forms and policy forms use will not be met if any exception is identified.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during this examination is stated in this Report and the results are reported below.

The examiners reviewed 35 Department and 25 consumer complaints sent directly to the Company. Company responses were complete, adequately documented and timely. The examiners found no trends or areas of concern.

The Company failed Claim Standard No. 3 because the Company failed to:

(a) provide a fraud warning on 15 claim forms and/or claim letters used during the examination period; and

(b) advise on two authorization forms that persons authorized to act on behalf of the individual were entitled to receive a copy of the authorization form.

The Company passed Claim Standard No. 5 with comment because the Company failed to:

(a) correctly calculate and fully pay sales tax in the settlement of one total loss; and

(b) correctly calculate and fully pay total fees in the settlement of one total loss.

The Company passed Claim Standard No. 10 with comment because the Company failed to advise one first party claimant of the proper coverage when their claim was presented.

The Company passed all other Complaint, Underwriting, Cancellation, Non-Renewal and Claim Standards.

FACTUAL FINDINGS
CLAIM STANDARD 3

The following Claim Standard Failed:

#	STANDARD	Regulatory Authority
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	A.R.S. § 20-466.03 A.R.S. § 20-2106(9)

Procedures Performed

The examiners reviewed the information provided by the Company in response to the Coordinator's Handbook, Attachments A and B, and follow-up requests that related to claim processing procedures. These documents and materials were reviewed without comment.

Phase I Examination – The Company provided electronic data in response to the Coordinator's Handbook, Attachment C. Attachment C requested private passenger automobile losses closed during the examination period. The examiners reviewed random samples of claim files from each of the following seven categories:

1st Party Total Losses Paid
1st Party Partial Losses Paid
1st Party Claims Closed Without Payment
Subrogated Claims Against 3rd Parties
3rd Party Total Losses Paid
3rd Party Partial Losses Paid
3rd Party Claims Closed Without Payment

From a population of claim forms and claim letters provided by the Company in response to Attachment A, the examiners identified 17 exceptions.

CLAIM FORMS

Failed to provide a fraud warning statement on 15 claim forms and/or claim letters in violation of A.R.S. § 20-466.03.

Population	Sample	# of Exceptions	Error Ratio*
95	95	15	15.8%

***Any claim form violation does not meet the Standard.**

Finding No. 1

The Company failed Claim Standard No. 3 because the Company failed to provide a fraud warning statement on 15 claim forms and/or letters used in correspondence with parties associated with a claim. [PF 1]

1	Medical Provider List - C-557 (12-03) NS
2	Repayment Method Questionnaire (5/2003)
3	Adverse Info Questionnaire (3/2001)
4	Mileage Reimbursement Request - Mileage Reimbursement Form (5/2003)
5	Outstanding Check Questionnaire (5/2003)
Letters requiring affirmative response from recipients -	
6	Additional Information to Support Reasonableness and Necessity Letter - EP0010 (1/2003)
7	Request of Provider for Completed Medical Application Form Letter - EP0019 (10/2004)
8	Information re Injury, Making or Not Making a Claim Letter - EP0018 (9/2004)

9	Request for Disability Statement Letter - EP0020 (10/2004)
10	Request for Updated Patient Information Letter - EP0021 (10/2004)
11	Request for Additional Information re Treatment Rendered Letter - EP0022 (10/2004)
12	Vehicle Information Letter - EC0023 (1/2003)
13	Request for CPT, ICD-9 Codes and MD's Tax ID# Letter - EP0025 (10/2004)
14	Follow-Up Request for Medical Reports and Documentation Letter - EC0046 (4/2004)
15	Request for Your MD to Verify Continuing Disability Letter - EC0051 (10/2004)

Recommendation No. 1

Within 90 days of the filed date of this Report, provide documentation that the required fraud warning statement, in 12-point type, is included on each of the claim forms and/or claim letters cited in accordance with the applicable state statute.

Failed to advise on two authorization forms that the individual or person(s) authorized to act on behalf of the individual were entitled to receive a copy of the authorization form in violation of A.R.S. § 20-2106(9).

Population	Sample	# of Exceptions	Error Ratio*
2	2	2	100%

***Any claim form violation does not meet the Standard.**

Finding No. 2

The Company failed Claim Standard No. 3 because the Company failed to advise on two authorization forms that the individual or person(s) authorized to act on behalf of the individual were entitled to receive a copy of the authorization form. [PF 2]

Description	Form #
HIPAA Complaint Authorization to Obtain Medical Records	Name - Arizona
Authorization to Obtain Leave and Salary Information	C-176 (10-03)

Recommendation No. 2

Within 90 days of the filed date of this Report, provide documentation that these forms provide an appropriate notice informing the individual or persons authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form in accordance with applicable state statute.

Subsequent Event

During the examination, the Company informed the examiners that they were in the process of programming necessary changes to ensure future compliance. The Company will submit the new forms to the Department once they are updated and in production.

CLAIM STANDARD 5

The following Claim Standard Passed with comment:

#	STANDARD	Regulatory Authority
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	A.R.S. §20-461(A) A.R.S. §20-462(A) A.A.C. R20-6-801

Procedures Performed

During the Phase I Examination, the examiners reviewed a sample of 100 total losses paid from a population of 2,187 and found two exceptions.

TOTAL LOSSES PAID

Failed to correctly calculate and fully pay sales tax in the settlement of one total loss and failed to correctly calculate and fully pay title, registration, air quality and other fees payable in the settlement of one total loss in violation of A.R.S. § 20-461(A)(6), 20-462(A) and A.A.C. R20-6-801(H)(1)(b).

Population	Sample	# of Exceptions	Error Ratio
2,187	100	2	2%

A 2% error ratio does meet the Standard; however, a comment is warranted since monies were returned.

Finding No. 3

The Company passed Claim Standard No. 5 with comment because the Company failed to correctly calculate and fully pay sales tax in the settlement of one total loss and failed to correctly calculate and fully pay title, registration, air quality and other fees in the settlement of one total loss. [PFs 6, 7]

Subsequent Event

During the examination, the Company resettled these claims, resulting in total restitution of $64.33, which included $7.76 interest.

CLAIM STANDARD 10

The following Claim Standard Passed with comment:

#	STANDARD	Regulatory Authority
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented.	A.R.S. §20-461(A) A.A.C. R20-6-801

Procedures Performed

During the Phase I Examination, the examiners reviewed a sample of 50 first party losses closed without payment from a population of 2,288 and found one exception.

FIRST PARTY - LOSSES CLOSED WITHOUT PAYMENT

Failed to advise the one first party claimant of the proper coverage when the claim was presented in violation of A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1).

Population	Sample	# of Exceptions	Error Ratio
2,288	50	1	2%

A 2% error ratio does meet the Standard; however, a comment is warranted since monies were returned.

Finding No. 4

The Company passed Claim Standard No. 10 with comment because the Company failed to advise one claimant of the proper coverage when the claim was presented. [PF 5]

Subsequent Event

During the examination, the Company resettled this claim, resulting in total restitution of $141.53, which included $17.74 interest.

SUMMARY OF STANDARDS

Complaint Handling

#	STANDARD	PASS	FAIL
1	The Company takes adequate steps to finalize and dispose of the complaints in accordance with applicable statutes, rules, regulations and contract language. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

Underwriting

#	STANDARD	PASS	FAIL
1	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463, 20-1109)	X	

Cancellations and Non-Renewals

#	STANDARD	PASS	FAIL
1	Declinations shall comply with state laws and company guidelines including the Summary of Rights to be given to the applicant and are not unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109, 20-2110)	X	
2	Cancellations and Non-Renewal notices comply with state laws, company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder and shall not be unfairly discriminatory. (A.R.S. §§ 20-191, 20-448, 20- 1631, 20-1632, 20-1632.01)	X	

Claims Processing

#	STANDARD	PASS	FAIL
1	The initial contact by the Company with the claimant is within the required time frame. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	Timely investigations are conducted. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations. (A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801)		X
4	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801)	X	
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. (A.R.S. §§ 20-268, 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801)	X	

#	STANDARD	PASS	FAIL
6	The Company uses reservation of rights and excess of loss letters, when appropriate. [A.R.S. § 20-461(A)(1), A.A.C. R20-6-801(D)(1)]	X	
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
8	The Company responds to claim correspondence in a timely manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law. (A.R.S. §§ 20-461, 20-462, 20-463, 20-466, A.A.C. R20-6-801)	X	
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
11	Claim handling practices do not compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	