THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION

MARKET INVESTIGATIONS

TARGET MARKET CONDUCT EXAMINATION FINAL REPORT

OF THE

FIRST PROTECTIVE INSURANCE COMPANY

ISSUED

April 22, 2016

NAIC COMPANY CODE: 10897

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EXECUTIVE SUMMARY

A target market conduct examination of the First Protective Insurance Company was performed to determine insurer compliance with Market Conduct Annual Statement (MCAS) reporting of the company's transactions and affairs. MCAS reporting provides participating MCAS states with a uniform method of collecting key data elements from insurers. MCAS data is provided and maintained under confidentiality agreements. The examination determined the Company made 27 report line errors in each of the 2011 and 2012 MCAS Homeowners Reports and 26 errors maintaining complete records of complaints received from consumers.

PURPOSE AND SCOPE OF EXAMINATION

The Florida Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of the First Protective Insurance Company (herein after First Protective or Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Global Insurance Enterprises, Inc. The scope of the examination was January 1, 2011 through December 31, 2012. The field examination began October 13, 2014, and ended October 17, 2014. Off-site analysis concluded May 22, 2015.

Examination procedures included reconciling policy data to the 2011 and 2012 Market Conduct Annual Statement Homeowners Reports, reviewing samples of contracts and claims file attributes, the insurer Anti-Fraud Plan, Special Investigations Unit (SIU) descriptions filings, and consumer complaints.

This Report is based upon information obtained during the examination, research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners (NAIC).

COMPANY BACKGROUND

First Protective Insurance Company is a Florida property and casualty insurer writing Fire, Allied Lines, Homeowners Multi-peril, Other Liability, Mobile Home Multi-peril, Mobile Home Physical Damage, and Miscellaneous Casualty insurance. The Company received a Certificate of Authority on April 3, 1998 and operates as Frontline Homeowners Insurance, a wholly owned subsidiary of PWC Financial, Inc. First Protective also writes coverage in Alabama, Delaware, Maryland, North Carolina, and South Carolina. Retail coverages are produced through a network of independent agents and brokers.

Direct Written Premiums in Florida represented 98.9% and 94.2% of all direct written premiums in 2013 and 2014, respectively and 100% of direct written premiums in 2011 and 2012.

Total Florida Direct Written Premiums and All Direct Written Premiums

Year	Florida Direct Written Premiums	All Direct Written Premiums	Percent of Total
2014	$ 111,862,239	$ 118,714,286	94.2%
2013	$ 114,840,215	$ 116,033,575	98.97%
2012	$ 110,238,816	$ 110,238,816	100.00%
2011	$ 107,451,580	$ 107,451,580	100.00%

FILE REVIEW

File reviews consisted of sample testing of select reporting lines and reconciliation of the company data sets to filed MCAS reports. The examiners reviewed information contained in the policy and claims administration system and complaint logs. The Company identified Frontline Insurance Managers, Inc. as its Managing General Agent responsible for policy administration, binding, underwriting, premium collection, and reinsurance negotiation services. Torrent Technologies performs binding, underwriting, and policy premium collection services of the Company's federal flood insurance business.

MCAS REPORTING

This examination reviewed the insurer's MCAS processes and procedures for collecting, aggregating, and extracting data used in the filing of the 2011 and 2012 MCAS Homeowner Reports. Each MCAS contains interrogatories, and those interrogatories for 2011 and 2012 are provided in the appendices of this report of examination. Instructions for completing reports are made available to insurers each year through the National Association of Insurance Commissioners (NAIC). All reports are attested to the completeness and accuracy of the submission. Such reports are filed in accordance with the requirements of Section 626.424, Florida Statutes.

EXAM PROCEDURES

The Company was asked to provide complete data sets utilized in the 2011 and 2012 MCAS Homeowners Reports and for samples of selected reporting lines. Procedures for evaluating each report and line examined included the reconciliation of information filed against the universe of files provided, analysis to determine accuracy of information reported and of the applicable contracts, and verification that data and files are maintained and reported in accordance with the Florida Insurance Code. The Company agrees with the findings except where noted. Findings are reported by exception basis.

2011 MCAS HOMEOWNERS REPORT

MCAS Homeowners reporting for the calendar year 2011 consists of the responses to 47 interrogatories. The examiners selected 6 lines for sampling review and 38 responses for reconciliation review to the Company data sets. The examination identified 27 reporting errors in the filing of the 2011 MCAS Homeowners Report.

CLAIMS OPEN AT THE BEGINNING, DURING AND AT THE END OF THE PERIOD

The examination reviewed the Number of Claims Open at the Beginning of the Period- Line 17, the Number of Claims Opened during the Period- Line 18 and, the Number of Claims Open at the End of the Period- Line 21. In addition, the examiners selected for testing a sample of 10 files from Line 21. The examiners identified an error on Line 17 reporting the Number of Claims Open at the Beginning of

the Period, an error on Line 18 reporting the Number of Claims Opened during the Period and, an error on Line 21reporting the Number of Claims Open at the End of the Period.

CLAIMS CLOSED WITH PAYMENT

The examination reviewed the Number of Claims Closed with Payment during the Period- Line 19, the Number of Claims Closed without Payment during the Period- Line 20. The examination also reviewed the Number of Claims Closed with Payment during the Period within 0-30 Days- Line 23, the Number of Claims Closed with Payment during the Period within 31-60 Days- Line 24, the Number of Claims Closed with Payment during the Period within 61-90 Days- Line 25, the Number of Claims Closed with Payment during the Period within 91-180 Days- Line 26 and, the Number of Claims Closed with Payment during the Period beyond 365 Days- Line 28.

The examiners identified an error on Line 19 reporting the Number of Claims Closed with Payment during the Period and an error on Line 20 reporting the Number of Claims Closed without Payment during the Period. The examiners also identified an error on Line 23 reporting the Number of Claims Closed with Payment during the Period within 0-30 Days, an error on Line 24 reporting the Number of Claims Closed with Payment during the Period within 31-60 Days, an error on Line 25 reporting the Number of Claims Closed with Payment during the Period within 61-90 Days, an error on Line 26 reporting the Number of Claims Closed with Payment during the Period within 91-180 Days and, an error on Line 28 reporting the Number of Claims Closed with Payment during the Period beyond 365 Days.

MERIDIAN DAYS TO FINAL PAYMENT

The examination reviewed the Median Days to Final Payment-Line 22 and identified an error reporting the Median Days to Final Payment.

CLAIMS CLOSED WITHOUT PAYMENT

The examination reviewed the Number of Claims Closed without Payment during the Period within 0-30 Days- Line 29, the Number of Claims Closed without Payment during the Period within 31-60 Days- Line 30, the Number of Claims Closed without Payment during the Period within 61-90 Days- Line 31, the Number of Claims Closed without Payment during the Period within 91-180 Days- Line 32, the Number of Claims Closed without payment during the Period within 181-365 days- Line 33 and, the Number of Claims Closed without Payment during the Period beyond 365 Days- Line 34. In addition, the examiners selected for testing a sample of 5 files from Line 32 and 5 files from Line 33.

The examiners identified an error on Line 29 reporting the Number of Claims Closed without Payment during the Period within 0-30 Days, an error on Line 30 reporting the Number of Claims Closed without Payment during the Period within 31-60 Days, an error on Line 31 reporting the Number of Claims Closed without Payment during the Period within 61-90 Days and, an error on Line 32 reporting the Number of Claims Closed without Payment during the Period Within 91-180 Days, an error on Line 33 reporting the Number of Claims Closed without Payment during the Period Within 181-365 days and, an error on Line 34 reporting the Number of Claims Closed without Payment during the Period beyond 365 Days.

COMPANY RESPONSE

The Company disagreed with the findings identified in the sample reviews, responding: “[the] policy was already expired at the time of the claim notice and was closed in 2010. This claim was reopened for

administrative purposes (in 2011) to be reviewed for quality assurance purposes." In another example, the Company responds: "[the] claim file was closed in November of 2010. In February of 2011, we received correspondence from the claimant with additional information, which triggered the reserve to be re-opened. After review, the claim was closed."

The examination acknowledges the Company procedures; however, the claim was closed with payment.

SUITS DURING THE PERIOD

The examination reviewed the Number of Suits Open at the Beginning of the Period- Line 35, the Number of Suits Opened during the Period- Line 36, the Number of Suits Closed during the Period- Line 37 and, the Number of Suits Open at the End of the Period- Line 38. The examiners selected for testing a sample of 5 files from Line 36.

The examiners identified an error on Line 35 reporting the Number of Suits Open at the Beginning of the Period, an error on Line 36 reporting the Number of Suits Opened during the Period, an error on Line 37 reporting the Number of Suits Closed during the Period and, an error on Line 38 reporting the Number of Suits Open at the End of the Period.

NUMBER OF NEW POLICIES

The examination reviewed the Number of New Policies Written during the Period- Line 41. The examiners identified an error on Line 41 reporting the Number of New Policies Written during the Period.

NON-RENEWALS

The examination reviewed the Number of Company-Initiated Non-Renewals during the Period- Line 43. In conjunction with the review, the examiners selected for testing 5 files from the Number of Company-Initiated Cancellations that Occur Greater than 90 Days from the Effective Date, Excluding Rewrites to a Related Company-Line 47. The examiner's identified an error on Line 43 reporting the Number of Company-Initiated Non-Renewals during the Period.

CANCELLATIONS

The examination reviewed the Number of Cancellations for Non-Pay, Non-Sufficient Funds, or Insured's Request during the Period- Line 44. In conjunction with the review, the examiners selected for testing 5 files from the Number of Company-Initiated Cancellations that Occur 60-90 Days after the Effective Date, Excluding Rewrites to a Related Company-Line 46. In addition, the examination reviewed the Number of Company-Initiated Cancellations that Occur in the First 59 Days after Effective Date, Excluding Rewrites to a Related Company- Line 45, the Number of Company-Initiated Cancellations That Occur 60-90 Days after Effective Date, Excluding Rewrites to a Related Company-Line 46 and, the Number of Company-Initiated Cancellations that Occur Greater than 90 Days after Effective Date, Excluding Rewrites to a Related Company- Line 47. In conjunction with the review of Line 47, the examiners selected for testing 5 files from the Number of Company-Initiated Cancellations that Occur 60-90 Days after Effective Date, Excluding Rewrites to a Related Company- Line 46.

The examiners identified an error on Line 44 reporting the Number of Cancellations for Non-Pay, Non-Sufficient Funds, or Insured's Request during the Period, an error on Line 45 reporting the Number of Company-Initiated Cancellations that Occur in the First 59 Days after Effective Date, Excluding Rewrites to a Related Company, an error on Line 46 reporting the Number of Company-Initiated

Cancellations That Occur 60-90 Days after Effective Date, Excluding Rewrites to a Related Company- Line 46 and, an error on Line 47 reporting the Number of Company-Initiated Cancellations that Occur Greater than 90 Days after Effective Date, Excluding Rewrites to a Related Company.

RECOMMENDATION

It is recommended the Company adopt policies and procedures to improve reporting accuracy.

2012 MCAS HOMEOWNERS REPORT

MCAS Homeowners reporting for calendar year 2012 consisted of the responses to 45 interrogatories. The examiners selected 6 lines for sampling review and 38 lines for reconciliation review to the Company data sets. The examination identified 27 errors in the filing of the 2012 MCAS Homeowners Report.

CLAIMS OPEN, DURING AND AT THE END OF THE PERIOD

The examination reviewed the Number of Claims Open at the Beginning of the Period- Line 14, the Number of Claims Opened during the Period- Line 15 and the Number of Claims Open at the End of the Period- Line 18. The examiners identified an error on Line 14 reporting the Number of Claims Open at the Beginning of the Period, an error on Line 15 reporting the Number of Claims Opened during the Period and, an error on Line 18 reporting the Number of Claims Open at the End of the Period.

CLAIMS CLOSED WITH PAYMENT

The examination reviewed the Number of Claims Closed with Payment during the Period- Line 16, the Number of Claims Closed with Payment during the Period within 0-30 Days- Line 20, the Number of Claims Closed with Payment during the Period within 31-60 Days- Line 21, the Number of Claims Closed with Payment during the Period within 61-90 Days- Line 22, the Number of Claims Closed with Payment during the Period within 91-180 Days- Line 23, the Number of Claims Closed with Payment during the Period within 181-365 Days- Line 24 and, the Number of Claims Closed with Payment during the Period beyond 365 Days- Line 25.

The examiners identified an error on Line 16 reporting the Number Claims Closed with Payment during the Period, an error on Line 20 reporting the Number of Claims Closed with Payment during the Period within 0-30 Days, an error on Line 21 reporting the Number of Claims Closed with Payment during the Period within 31-60 Days, an error on Line 22 reporting the Number of Claims Closed with Payment during the Period within 61-90 Days, an error on Line 23 reporting the Number of Claims Closed with Payment during the Period within 91-180 Days, an error on Line 24 reporting the Number of Claims Closed with Payment during the Period within 181-365 Days and, an error on Line 25 reporting the Number of Claims Closed with Payment during the Period beyond 365 Days.

MEDIAN PAYMENT TO FINAL PAYMENT

The examiners reviewed the Median Days to Final Payment- Line 19 and identified an error reporting the Median Days to Final Payment.

CLAIMS CLOSED WITHOUT PAYMENT

The examination reviewed the Number of Claims Closed without Payment during the Period- Line 17, the Number of Claims Closed without Payment during the Period within 0-30 Days- Line 26, the Number of Claims Closed without Payment during the Period within 31-60 Days- Line 30 and, the Number of Claims Closed without Payment during the Period beyond 365 Days- Line 31.

The examiners identified an error on Line 17 reporting the Number of Claims Closed without Payment during the Period, an error on Line 26 reporting the Number of Claims Closed without Payment during the Period within 0-30 Days, an error on Line 30 reporting the Number of Claims Closed without Payment during the Period within 31-60 Days and, an error on Line 31 reporting the Number of Claims Closed without Payment during the Period beyond 365 Days.

SUITS DURING THE PERIOD

The examination reviewed the Number of Suits Open at the Beginning of the Period- Line 32, the Number of Suits Opened during the Period- Line 33, the Number of Suits Closed during the Period- Line 34 and, the Number of Suits Open at the End of the Period- Line 35. The examiners selected a sample of 5 files for testing from Line 33.

The examiners identified an error on Line 32 reporting the Number of Suits Open at the Beginning of the Period, an error on Line 33 reporting the Number of Suits Opened during the Period, an error on Line 34 reporting the Number of Suits Closed during the Period and, an error on Line 35 reporting the Number of Suits Open at the End of the Period.

NUMBER OF NEW POLICIES AND PREMIUM WRITTEN

The examination reviewed the Number of New Policies Written during the Period- Line 38 and the Dollar Amount of Direct Written Premium during the Period- Line 39. The examiners identified an error on Line 38 reporting the Number of New Policies Written during the Period and an error on Line 39 reporting the Dollar Amount of Direct Written Premium during the Period.

NON-RENEWALS

The examination reviewed the Number of Company-Initiated Non-Renewals during the Period- Line 40. The examiners reviewed the company-initiated non-renewals in conjunction with Line 44- the Number of Company-Initiated Cancellations that Occur Greater than 90 Days after the Effective Date, Excluding Rewrites to a Related Company. In addition, the examiners selected for testing a sample of 5 files from Line 40. The examiners identified an error on Line 40 reporting the Number of Company-Initiated Non-Renewals during the Period.

CANCELLATIONS

The examination reviewed the Number of Cancellations for Non-Pay, Non-Sufficient Funds, or Insured's Request during the Period- Line 41. The examiners reviewed company-initiated cancellations in conjunction with testing of a sample of 5 files selected from Line 43– the Number of Company-Initiated Cancellations that Occur 60-90 Days after the Effective Date, Excluding Rewrites to a Related Company that resulted in findings for Line 41. In addition, the examiners reviewed company initiated-cancellations in conjunction with testing of a sample of 5 files selected from Line 44- the Number of Company-Initiated Cancellations that Occur Greater than 90 days after effective date, Excluding Rewrites to a Related Company, the Number of Company-Initiated Cancellations that Occur in the First 59 Days after Effective Date, Excluding Rewrites to a Related Company- Line 42, the Number of

Company-Initiated Cancellations that occur 60-90 Days after Effective Date, Excluding Rewrites to a Related Company- Line 43.

In addition, the examination reviewed the Number of Company-Initiated Cancellations that Occur Greater than 90 Days after Effective Date, Excluding Rewrites to a Related Company- Line 44. The examiners reviewed these company-initiated cancellations in conjunction with Line 43– the Number of Company-Initiated Cancellations that Occur 60-90 Days after the Effective Date, Excluding Rewrites to a Related Company.

The examiners identified an error on Line 41 reporting the Number of Cancellations for Non-Pay, Non-Sufficient Funds, or Insured's Request, an error on Line 42 reporting the Number of Company-Initiated Cancellations that Occur in the First 59 Days after Effective Date, Excluding Rewrites to a Related Company, an error on Line 43 reporting the Number of Company-Initiated Cancellations that Occur 60-90 Days after Effective Date, Excluding Rewrites to a Related Company and, an error on Line 44 reporting the Number of Company-Initiated Cancellations that Occur Greater than 90 Days after the Effective Date, Excluding Rewrites to a Related Company.

COMPLAINTS

The examination reviewed the Number of Complaints Received Directly from Consumers during the Period- Line 45. The examiners identified an error reporting the Number of Complaints Received Directly from Consumers.

COMPANY RESPONSE

The Company disagreed with the findings, responding: "The Company inadvertently misread the instructions…and reported the Complaints registered with DFS."

The examination acknowledges the finding is the result of an inadvertent error.

RECOMMENDATION

It is recommended the Company adopt policies and procedures to improve reporting accuracy.

COMPLAINT REGISTERS

The examination reviewed the 2010 through 2012 Florida Department of Financial Services Division of Consumer Services (FLDFS) complaint logs against the Company registers of complaints received directly from consumers.

The examiners determined the Company registers of complaints in 26 instances did not agree with the FLDFS logs of complaints received from consumers. Section 626.9541(1)(j), Florida Statutes, stipulates the insurer maintain complete complaint records. The examiners also concluded Company narratives for processing complaints received from FLDFS does not explain how complaints received are shared and reviewed by Company management.

COMPANY RESPONSE

The Company disagreed with the findings, responding: "written complaints procedures were scattered across departments...we have followed up the initial advisory with all procedures combined into one document and distributed to all the responsible parties for complaint handling reference."

RECOMMENDATION

It is recommended the Company adopt policies and procedures to improve reporting accuracy.

ANTI-FRAUD PLAN

The Company files an Anti-Fraud Plan with the Florida Department of Financial Services, Division of Insurance Fraud (Division). Special Investigations Unit (SIU) description filings are made to the Division electronically. The Company Anti-Fraud Plan and SIU description filings for the examination period through the on-site analysis date were reviewed. The examiners determined the Company records appear in compliance with Section 626.9891(3), Florida Statutes, and Rule 69D-2, Florida Administrative Code.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company

APPENDIX A

Line	INTERROGATORIES 2011 MCAS HOMEOWNERS
01	Does the company have data to report for Dwelling?
02	If yes, enter type of Claim Count Indicator (Occurrence = "O," Claimant = "C").
03	Does the company have data to report for Personal Property?
04	If yes, enter type of Claim Count Indicator (Occurrence = "O," Claimant = "C").
05	Does the company have data to report for Liability?
06	If yes, enter type of Claim Count Indicator (Occurrence = "O," Claimant = "C").
07	Does the company have data to report for Medical Payments?
08	If yes, enter type of Claim Count Indicator (Occurrence = "O," Claimant = "C").
09	Was the company actively writing policies in the state at year end?
10/11	Did the Company have a significant event or business strategy change that would affect data for this reporting period? If yes, explain.
12/13	Has all or part of this block of business been sold, closed, or moved to another company during the year? If yes, explain.
14	How does the company treat supplemental or additional payments on previously reported claims?
15	Additional state specific Claims comments (optional):
16	Additional state specific Underwriting comments (optional):
17	Number of claims open at the beginning of the period.
18	Number of claims opened during the period.
19	Number of claims closed with payment during the period.
20	Number of claims closed without payment during the period.
21	Number of claims open at the end of the period.
22	Median days to final payment.
23	Number of claims closed with payment within 0-30 days.
24	Number of claims closed with payment within 31-60 days.
25	Number of claims closed with payment within 61-90 days.
26	Number of claims closed with payment within 91-180 days.
27	Number of claims closed with payment within 181-365 days.
28	Number of claims closed with payment within beyond 365 days.
29	Number of claims closed without payment within 0-30 days.
30	Number of claims closed without payment within 31-60 days.
31	Number of claims closed without payment within 61-90 days.
32	Number of claims closed without payment within 91-180 days.
33	Number of claims closed without payment within 181-365 days.
34	Number of claims closed without payment beyond 365 days.
35	Number of suits open at the beginning of the period.

Line	INTERROGATORIES 2011 MCAS HOMEOWNERS (CONT)
36	Number of suits opened during the period.
37	Number of suits closed during the period.
38	Number of suits open at end of period.
39	Number of dwellings which have policies in force at the end of the period.
40	Number of policies in force at the end of the period.
41	Number of new policies written during the period.
42	Dollar amount of direct written premium during the period.
43	Number of company-initiated non-renewals during the period.
44	Number of cancellations for non-pay, non-sufficient funds or insured's request.
45	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
46	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
47	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.

APPENDIX B

Line	INTERROGATORIES 2012 MCAS HOMEOWNERS
01	Does the company have data to report for Dwelling?
02	Does the company have data to report for Personal Property?
03	Does the company have data to report for Liability?
04	Does the company have data to report for Medical Payments?
05	Does the company have data to report for Loss of Use?
06	Was the company actively writing policies in the state at year end?
07/08	Did the Company have a significant event or business strategy change that would affect data for this reporting period? If yes, explain.
09/10	Has all or part of this block of business been sold, closed, or moved to another company during the year? If yes, explain.
11	How does the company treat supplemental or additional payments on previously reported claims?
12	Additional state specific Claims comments (optional).
13	Additional state specific Underwriting comments (optional).
14	Number of claims open at the beginning of the period.
15	Number of claims opened during the period.
16	Number of claims closed with payment during the period.
17	Number of claims closed without payment during the period.
18	Number of claims open at the end of the period.
19	Median days to final payment.

	INTERROGATORIES 2012 MCAS HOMEOWNERS (CONT)
20	Number of claims closed with payment within 0-30 days.
21	Number of claims closed with payment within 31-60 days.
22	Number of claims closed with payment within 61-90 days.
23	Number of claims closed with payment within 91-180 days.
24	Number of claims closed with payment within 181-365 days.
25	Number of claims closed with payment within beyond 365 days.
26	Number of claims closed without payment within 0-30 days.
27	Number of claims closed without payment within 31-60 days.
28	Number of claims closed without payment within 61-90 days.
29	Number of claims closed without payment within 91-180 days.
30	Number of claims closed without payment within 181-365 days.
31	Number of claims closed without payment beyond 365 days.
32	Number of suits open at the beginning of the period.
33	Number of suits opened during the period.
34	Number of suits closed during the period.
35	Number of suits open at end of period.
36	Number of dwellings which have policies in force at the end of the period.
37	Number of policies in force at the end of the period.
38	Number of new policies written during the period.
39	Dollar amount of direct written premium during the period.
40	Number of company-initiated non-renewals during the period.
41	Number of cancellations for non-pay, non-sufficient funds or insured's request.
42	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
43	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
44	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
45	Number of complaints received directly from consumers.

FORM 118

FINANCIAL SERVICES COMMISSION
OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

I hereby certify that I am the officer in charge of the Florida business of:

First Protective Insurance Company

I have read the report of the ***Target Market Conduct Examination*** *issued on*

April 22, 2016

and filed with the Office of Insurance Regulation. Any recommendations contained in the report will be considered within a reasonable time.

This form is hereby executed in compliance with Section 624.319(5), Florida Statutes.

JJPA
Name

PRESIDENT
Title

LEMAN Miles PORTER
Signature

4/27/16
Date

Notary Public State of Florida
Jane E Bridges
My Commission EE 182821
Expires 06/30/2016

Sworn to and subscribed before me this 27
day of APRIL, 2016

(SEAL)

NOTARY PUBLIC Jane E. Bridges
Signature

My Commission Expires: 6/30/2016

This form is to be completed, notarized and returned to: Keith Nault, Senior Management Analyst I, Market Investigations, 200 East Gaines St., Larson Building, Tallahassee, Florida 32399-4210, within 30 days from receipt. If Form 118 is not returned to the Office within 30 days of the date of receipt, this matter will be forwarded to our Legal Division for appropriate legal action.