UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THOMAS POLLOCK AND EILEEN TABIOS, *Plaintiffs*, v. FEDERAL INSURANCE COMPANY, *Defendant*.	Civil Case No.: 21-cv-09975-JCS **DECLARATION OF CHARLES MILLER** Judge: The Honorable Joseph C. Spero

I, CHARLES MILLER, the undersigned declare as follows:

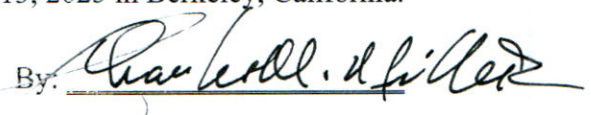
1. I have been engaged as an expert witness in this litigation by counsel for Plaintiffs and Counter-Claim Defendants Thomas Pollock and Eileen Tabios. I have personal knowledge of the facts as set forth in this declaration and if called as a witness could and would competently testify to them under oath.

2. On February 20, 2025, I submitted an expert report in this matter. A true and correct copy of that report is attached to the Declaration of Chris Nidel as Exhibit CCCCC found at ECF 236-4 at 40-172.

3. On August 19, 2025, I submitted an additional expert report in this matter. A true and correct copy of that report is attached hereto as Exhibit 1.

4. These reports fully and accurately set forth my opinions and conclusions in this action and describe the bases for those opinions and conclusions.

5. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on October 13, 2025 in Berkeley, California.

By: 

CHARLES MILLER

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF CALIFORNIA

THOMAS POLLOCK AND EILEEN TABIOS,

Plaintiffs,

vs.

FEDERAL INSURANCE COMPANY,

Defendant

Case No.: 21-cv-09975-JCS

SUPPLEMENTAL EXPERT REPORT OF CHARLES M. MILLER

I. INTRODUCTION

1. I have been retained by Thomas Pollock and Eileen Tabios (hereinafter, collectively referred to as "Pollock") to provide my expert opinion on whether Federal Insurance Company[1] (hereinafter, "Federal") complied with the practices and objective standards of the insurance industry for claims handling in its handling of Pollock's claim, which is the subject of this litigation. The purpose of this Supplemental Report is to provide additional opinions based on

[1] Federal and Chubb are used herein interchangeably.

documents and information received since by original report.[2] The opinions herein are offered to a reasonable degree of professional certainty.

II. SUMMARY OF OPINIONS

2. Several important additional opinions and observations are discussed herein based on information obtained since the Miller Report. First, it is apparent, based on numerous documents and testimony, that Chubb has adopted an incentive program that has the effect of lowering or delaying the payment of claims or encouraging the denial of claims, all of which result in claim payments lower than would otherwise be owed. This incentive program would have impacted the day to day handling of claims including the Pollock claim, and goes far in explaining why the Pollock claim was significantly underpaid. Second, Chubb has only recently alleged that Pollock has committed insurance fraud. Yet, Chubb's trained claims department, including its fraud investigation unit, never identified such fraud during the claim handling even though the basis for the current allegations were present during that claim handling. Finally, and as noted in the Miller Report, Chubb failed to put the mortgagee on notice of its claim denial. This issue was also addressed in the Miller Report but is revisited here because it further supports the opinion that Chubb has sought, through its incentive program and claim handling, to pay less on Pollock's claim that what was owed.

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[2] My report of February 20, 2025, is incorporated as though fully set forth herein (Hereinafter "Miller Report") .

III. ADDITIONAL OPINIONS

A. CHUBB HAS ADOPTED PROGRAMS AND POLICIES AIMED AT ARTIFICIALLY REDUCING, DELAYING OR DENYING CLAIM PAYMENTS WHICH ADVERSELY IMPACTED CHUBB'S PAYMENTS OF POLLOCK'S CLAIM.

1. Insurance Industry Standards Regarding Incentive Compensation and Performance Measurement Programs Aimed at Reducing Claims Payments.

a. Claims Department Incentive and Compensation Programs Have Been Criticized in Insurance Industry Publications.[3]

3. Although an insurer must operate on a profitable basis, it is not proper for an insurer to use its claims operation as a profit center—in other words, to turn the claims department into a profit source. It is also widely recognized that programs aimed at providing compensation and bonuses that are directly related to the financial performance of the insurance company will incentivize employees to improperly reduce the amount paid on claims (See Petitta, Joseph P., Insurance Practice for the Millennium [2000; hereinafter, "Petitta"], p. 42, for a discussion of why it is contrary to insurance industry claims handling standards to measure a claims adjuster's performance using an

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[3] Likewise, several courts have criticized such programs (See, e.g., *Chubb Auto. Ins. Co. v, Shrader* (WY 1994), 882 P.2d 813, 836; *Albert H. Wohlers and Co. v. Bartgis* (NV 1998), 969 P.2d 949; *Campbell v. Chubb*, 65 P.3d 1134, 2001 UT 89 (Utah 10/19/2001) rev. in part; *Chubb Mutual Automobile Insurance Co. v. Campbell*, 123 S. Ct. 1513, 538 U.S. 408, 155 L.Ed.2d 585 (U.S. 2003); *Robinson v. Chubb Mutual Automobile Insurance Co.*, No. 24952 (Idaho 12/28/2000), rev. *Robinson v. Chubb Mutual Automobile Insurance Company*, 137 Idaho 173, 45 P.3d 829 (Idaho 04/10/2002); *Armstrong v. Aetna Life Ins. Co.* (8th Cir. 1997), 128 F.3d 1263, 1265; and *Zilisch v. Chubb Mut. Auto Ins. Co.*, (AZ 2000), 995 P.2d 276, 237–238).

average paid claim criteria; and see Quinley, Kevin M., CPCU, ARM AIC, AIM, ARe, "Prevent Bad Faith Risks from Adjuster Incentive Compensation Schemes," Claims magazine, Oct. 2004, for a discussion of why it is improper to provide bonuses or other compensation to claims personnel as a reward for their claims handling; and see Feinman, Jay M., Delay Deny Defend [Penguin Books, 2010]; and see Frey, Jay, "Insurance adjusters rewarded for shrinking claims checks," Insure.com, Sept. 21, 2000).[4] It is also noted in an insurance text that is used nationwide to train insurance adjusters on the handling of claims, that "[p]unitive damage awards might be influenced by the insurer's compensation plan. For example, if claim representatives receive incentive-based compensation to close claims quickly or to reduce claim payments, the insurer might run a greater risk of a punitive damage award" (Hoppes, Doris, The Claims Environment [IIA, 2nd ed., 2000], §§9.15–9.16). Finally, in the recent insurance industry text Claims Leadership and Organizational Alignment (The Institutes, 2nd ed., 2016), edited by Martin J. Frappolli and Ann E. Myhr, the authors point out that "[c]laim managers should be careful when communicating business objectives such as profit or loss ratio targets. . . . Instead of communicating specific financial objectives to their staff, managers should communicate claims best practices that guide cost-effective, but fair, claims management" (Id., §9.4).

[4] Jay Feinman is a Distinguished Professor of Law at Rutgers University.

4. Indeed, there is evidence that, over at least the past few decades, insurers have increasingly used the claims process as a profit center by delaying payment or outright denial of claims:

> Beyond theory, although the insurance industry obviously disputes the charge, there is substantial evidence that since the early 1990s, insurance companies have increasingly viewed the claims process not as the site for keeping their promise of security but as a profit center. Through systematic reorganization of the claims process, incentives to employees and managers, and more aggressive approaches to litigation, the companies have embarked on a strategy that increases profits at the expense of claimants. This development has taken place across property, casualty, and disability insurances as a whole.
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> (Feinman, Jay M., "The Insurance Relationship as Relational Contract and the 'Fairly Debatable' Rule for First-Party Bad Faith," San Diego Law Review, 46, pp. 553, 566–567 [2009; citations omitted])

b. State Departments of Insurance Have Adopted Regulations Which Prohibit Insurers From Linking Claims Payments and Compensation.

5. The harm that can arise from programs has also been recognized by State Departments of Insurance (See Utah Admin. Code, §R590-190-9(3), that Unfair Methods, Deceptive Acts and Practices include "compensation by an insurer of its employees, agents or contractors of any amounts which are based on savings to the insurer as a result of denying the payment of claims"). Further, California Ins. Code §796.02 provides:

> Compensation of a person retained by a disability insurer to review claims for health care services shall not be based on either of the following:
>
> (a) A percentage of the amount by which a claim is reduced for payment.

> (b) The number of claims or the cost of services for which the person has denied authorization of payment.

6. Similarly, Colorado includes as an unfair compensation practice the "[b]asing [of] the compensation of claims employees or contracted claims personnel, including compensation in the form of performance bonuses or incentives, on any of the following:

> (I) The number of policies canceled;
>
> (II) The number of times coverage is denied;
>
> (III) The use of a quota limiting or restricting the number or volume of claims; or
>
> (IV) The use of an arbitrary quota or cap limiting or restricting the amount of claims payments without due consideration for the merits of the claim."
>
> (C.R.S. 10-3-1104 (1)(hh)).

7. Likewise, in June 2007, the North Dakota Insurance Department (hereinafter, the "Department") reported on its Market Conduct Examination of Farmers Insurance Exchange (hereinafter, the "Report"). This Examination consisted of a review of Farmers' claims handling activities from January 1, 1990, through August 1, 2004 (Report, p. 1). According to the Report, the examination "included an investigation into Farmers' incentive programs and employee performance goals and evaluations as applied to [Farmers'] claims handling practices" (Id.). Based on its examination, the Department arrived at the following conclusions:

- As early as 1990 and before, the management of Farmers Insurance Exchange set various goals for claims handlers and other employees in an effort to increase company profits and thereby grow company surplus.

- The Company evaluated employee performance based on whether employees met the goals assigned by management. The performance evaluation process was designed to link to the Company's pay system. Employees were informed that their individual performance ratings would play a key role in determining their pay level each year.
- Many of the performance goals for individual claims employees were appropriate. However, goals that were arbitrary and unfair to policyholders and claimants were also identified.
- "The Bismarck Branch Claims Office's PP&Rs included unfair and arbitrary goals (1) to maintain an average cost claim, not allowing for inflationary amounts, at the previous year's level or below, (2) to settle bodily injury claims within a predetermined range and maintain average medical payment amounts, (3) to utilize comparative negligence in at least a certain set percentage of claims, (4) to increase the number of fraud referrals, (5) to decrease the number of claimants that hire an attorney, (6) to close a set percentage of claims without payment, (7) to estimate the condition of damaged vehicles at or below the national average to minimize indemnity payments, and (8) to require that Quality Assurance overpayments be no more than a small percentage of the total claim payments, as determined by a subjective after the fact audit. These goals were set without regard to the nature or merits of the individual claims that might be handled by the individual claims settlement personnel."
- The Company evaluated the performance of claims employees based, in part, on these unfair and arbitrary goals.
- These unfair and arbitrary goals do not take into account or make allowance for the unique circumstances or facts of each individual claim.
- Slogans such as "Bring Back a Billion" and incentive programs such as "Quest for Gold" may have created certain bias or interest on the part of claims handlers to pay less on claims.
- The unique circumstances and facts which comprise each individual claim are beyond the control of claims handlers.
- Because meeting these unfair and arbitrary goals was a part of the performance evaluation process and, therefore, linked to an employee's pay, a potential conflict of interest

> was created between meeting these goals and effectuating a prompt, fair, and equitable settlement of each individual claim on its merits. This potential conflict may have created a certain bias or interest on the part of claims handlers, in some instances, to pay less on claims or to handle claims in an inappropriate manner in order to meet these goals.
>
> - "The adoption and use of the performance goals identified in Examiners Finding No. 4 [fourth bullet point above] to assess the performance of claims handling employees constitutes an unfair practice in the business of insurance under N.D. Cent. Code §26.1-04-02 and an unfair claim settlement practice under N.D. Cent. Code § 26.1-04-03(9)."

8. Based on its findings, the Department and Farmers entered into a Consent Order, No. Mc-04-149, whereby Farmers agreed to pay an administrative penalty of $750,000.

c. Incentive Compensation Programs Have Been Criticized in Other Literature.

9. The adverse impact of goal setting, such as the goals instituted by Chubb in its claims operation, has been discussed and demonstrated in the article, "The Dark Side of Goal Setting: The Role of Goals in Motivating Unethical Decision Making," by Maurice E. Schweitzer, Lisa Ordonez, and Bambi Douma (Academy of Management Proceedings, 2002 MOC). There, the authors point out that "goal setting motivates unethical behavior. This is true for goals both with and without economic incentives" (Id., p. 1). Similarly, in the article "Goals Gone Wild: The Systematic Side Effects of Over-Prescribing Goal Setting" (Harvard Business School, 2009), the same authors, along with Adam D. Galinsky and Max H. Berman, point out that "the beneficial effects of goal setting have been overstated and that systematic harm caused by goal setting has been largely ignored. We identify specific side effects associated with goal

setting, including a narrow focus that neglects non-goal areas, a rise in unethical behavior, distorted risk preferences, corrosion of organizational culture, and reduced intrinsic motivation," and "[w]e describe how the use of goal setting can degrade employee performance, shift focus away from important but non-specified goals, harm interpersonal relationships, corrode organizational culture, and motivate risky and unethical behaviors" (Id., and see, e.g., Stewart, Richard E., "The Loss of the Certainty Effect," Risk Management and Insurance Review, 2001, Vol. 4, No. 2 [hereinafter, "Stewart"]; Mitchell, Daniel J. B., Lewin, David, & Lawler II, Edward E., "Alternative Pay Systems, Firm Performance, and Productivity" [Brookings Institution, Washington, DC, 1990]; Balkin, Gomez-Meja, "Compensation, Organization Strategy, and Firm Performance," South-Western Series in Human Resources Management, p. 281; Gupta, Nina, & Shaw, Jason D., "Let The Evidence Speak: Financial Incentives Are Effective," Compensation and Benefits Review, March/April 1998, p. 144; and Baker, George P., Jensen, Michael C., & Murphy, Kevin J., "Compensation and Incentives: Practice vs. Theory," The Journal of Finance, July 1988, p. 593).[5]

[5] The adverse impact of goal setting is aptly demonstrated in the recent developments at Wells Fargo Bank. According to the September 8, 2016, Consent Order Issued by the U.S. Consumer Financial Protection Bureau, Administrative Proceeding 2016, CFPB-0015, Wells Fargo "set sales goals and implemented sales incentives, including an incentive-compensation programs, in part to increase the number of banking products and services that its employees sold to its customers," and that "[t]housands of Respondent's employees engaged in Improper Sales Practices to satisfy sales goals and earn financial rewards under Respondent's incentive-compensation program" (Id., p.

d. The Insurance Industry Has Recognized the Conflict of Interest Between Compensation and Claims Payments.

10. Insurance companies themselves recognize that cash or in-kind payments to insurance claims handlers can influence how those claim handlers will conduct themselves. Accordingly, insurance companies have put into place codes of ethics aimed at preventing their claims handlers from receiving compensation that would likely improperly influence their claims handling. As was noted in one insurance industry publication on insurance ethics:

> Claims representatives should make decisions based on the best interests of their customers. Anytime a claim representative allows the pursuit of his or her personal interests to interfere with the customers interests, a conflict of interest exists.
>
> . . .
>
> A claim representative, fist-line manager, estimator or other person who can refer clients to vendors or assign files for service will be actively lobbied by people seeking referrals. These people will seek to influence the claim representative with dinners at fine restaurants, the use of a boat for the season, a condominium at a popular vacation spot, and even direct payments of cash.
>
> . . .
>
> Each favor or gratuity that the claim representative accepts influences his or her decision-making ability.

4; and see "Wells Fargo Warned Workers Against Sham Accounts, but 'They Needed a Paycheck,'" *The New York Times*, September 16, 2016; and "Wells Fargo's pressure-cooker sales culture comes at a cost," *Los Angeles Times*, December 21, 2013; and "Class Action Suit Filed in California Over Wells Fargo's Alleged Consumer Account Abuses," *Consumerist*, May 14, 2015).

> ("Ethics and Claim Professionalism" [IIA, 1999], pp. 10–11)[6]

11. The ethics codes of insurers strongly echo the recognition that receipt of gratuities can influence claims handling and should not be allowed. Accordingly, the Hartford Code of Ethics and Business Conduct provides the following guidance:

> In order to maintain the Company's reputation and integrity, it is the responsibility of every employee to avoid conflicts of interest, or situations that create even the appearance of a conflict of interest. . . . For example, an employee's ability to make objective business decisions could be affected by potential conflicts if they were to: 1) accept valuable or an excessive number of gifts from business partners, 2) accept additional employment by another company, 3) have a financial interest in a business partner or competitor, 4) place business with any firm in which the employee or an immediate family member or an employee . . . has a financial interest, or 5) inappropriately communicate with competitors.
>
> (Id., p. 8)

12. Similarly, the American Family Code of Conduct & Business Ethics provides the following guidance:

> You must exercise good judgment, independent from any outside influence, avoiding activities and personal interests that create a potential conflict between your interests and the interests of the company.
>
> You should not receive any improper benefits from your position with the company, nor should your relatives. Conflicts may arise from a variety of

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[6] Likewise, in the text Winning by the Rules: Ethics and Success in the Insurance Profession (Nat'l. Underwriter, 2008), the author, Ken Brownlee, points out that "[a]djusters may not accept gifts or payments from parties with whom they are doing business" (Id., p. 126).

> situations, including ownership interests in other business, outside employment, contracting with relatives, and acceptance of gifts.
>
> (Id., p. 10)

13. Richard L. Arguette, an American Family Front Line Large Loss Claims Manager, testified in the matter of Donald Woelfle v. Chubb Property & Casualty Ins. Vo., et al., Sup. Ct., King Cty, WA, Case No. 21-2-09336-8 SEA (hereinafter, the Woelfle Action), that American Family had a code of conduct that limited the amount claims personnel could accept as gifts or gratuities to "$25 or less." (Arquette deposition, p. 75, and see Barkley deposition, pp. 26-28).[7] Arquette confirmed that the reason for such limitation was because the company did not want the claims handler's decision making to be impacted by gifts or gratuities from individuals or companies that the claims handlers were giving work to. (Id.).

14. Chubb also has a code of conduct. According to Chubb:

> The Chubb Code of Conduct is at the heart of our corporate culture to drive every business decision our executives and employees make. The Board considers Chubb's values-oriented culture to be a key factor in mitigating risky behavior.
>
> (2025 Chubb Proxy Statement, p. 83).

15. Elsewhere, Chubb notes:

> Chubb has adopted a Code of Conduct, which sets forth standards by which all Chubb employees, officers,

[7] Depositions cited herein from the Woelfle Matter are not subject to a protective order.

> and directors must abide as they work for Chubb. Chubb has posted this Code of Conduct on its internet site.
>
> (2019 10-K, p. 96).

16. Many other insurers have similar requirements (See, e.g., Allstate P-CCSO Code of Ethics, p. 9, "A conflict of interest or the appearance of a conflict may arise in an employee's own personal investment decisions when the employee uses information which Allstate owns or which the employee obtains in the course of work for the Company"; Safeco Corporation Code of Business and Financial Conduct and Ethics, p. 2, "You cannot engage in any activity that adversely affects your independent and objective judgment [or] interferes with your timely and effective job performance"; AFLAC Corporate Code of Ethics, p. 1, "Employees and Company representatives are to exercise independent judgment from any outside influence"; and Farmers Code of Business Ethics, that conflicts could arise from "[t]he acceptance of gifts, gratuities, special concessions, invitations to sporting events, theatres, excursions, or other social functions").

17. There is near-universal recognition in the insurance industry that something as little as a "gratuity" or "gift" can improperly influence an employee's conduct. Clearly, the insurance industry acknowledges the potential, if not real, impact on behavior of financial rewards. Nonetheless, the insurance industry's recognition of these improper financial influences has not always extended to the payment of bonuses or equity interests to claims department personnel, which are connected to the financial performance of an insurer. This is the case, even though it is recognized that such payments can adversely influence behavior. The insurance industry's own ethical standards

are a clear acknowledgement that financial benefits can improperly affect employee conduct. That is clearly what occurred in this matter.

18. The importance of such financial incentives in determining claims handling behavior has long been recognized in the insurance industry. In the text Organizational Behavior in Insurance, Vol. I, the authors, some of whom are employed in the insurance industry, point out:

> [C]hanging the reward system is a powerful way to introduce change into the organization culture because the reward system is one of the most important aspects of that culture. Developing a reward system is a type of behavioral modification, which represents one way of changing underlying beliefs. Reinforcement is a key aspect of socialization. If someone is consistently rewarded for doing something, human nature being what it is, that person will continue to do it. . . . Effective reward systems include many levels of rewards, including not only financial bonuses but also career- and stature-related rewards.
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> (White, George A. [Ed.] et al., Organizational Behavior in Insurance, Vol. 1 [Ins. Inst. of Am., 1st ed., 1992], p. 47).

2. Chubb Has Adopted Financial Incentive Programs That Are Contrary to Insurance Industry Claims Handling Standards Because They Motivate Adjusters to Delay, Wrongfully Deny or Underpay Insurance Claims.

19. A review of several Chubb documents reveals that Chubb has instituted various pay for performance programs and policies that would have the effect of artificially reducing, limiting, delaying or denying claim payments, all of which is contrary to insurance industry standards and which likely had an adverse impact on Pollock's claim. (See Chubb's 2025 Proxy Statement, p. 42, "Our compensation practices are structured to: pay for performance," and see Chubb's 2021 Proxy Statement, p. 82, "We structure our compensation program

to fairly compensate our management and **to enhance shareholder value by continuing to closely align our executive compensation program and practices with the interests of our shareholders**" (emphasis added)). These programs include Chubb's Limited 2016 Long-Term Incentive Plan, the ACE Limited 2004 Long-Term Incentive Plan, Chubb Corporation Long-Term Incentive Plan including various bonuses and stock ownership programs. (Chubb's 2021 Proxy Statement, pp. 33-36 & 9).

20. Chubb's "Invitation and Proxy Statement for the 2025 Annual General Meeting of Shareholders," dated May 15, 2025 (hereinafter, "Chubb's 2025 Proxy Statement), sets forth how Chubb determines compensation. This is done in three columns all with the heading "How Our Compensation Program Works."[8] The first column is entitled "What We Reward," where Chubb lists the following:

- **Superior operating and financial performance, as measured against prior year.** Board approved plan and peers.
- Achievement of strategic goals
- Superior underwriting and risk management in all of our business activities.

(Chubb 2025 Proxy Statement, pp. 5 & 75 (emphasis added) and see Chubb's Invitation and Proxy Statement for the 2021 Annual General Meeting of Stockholders, and see "Chubb's 2021 Proxy Statement, p. 5, same).

[8] The first two columns of this section are not limited to any particular class of employees.

21. The Second column is entitled "How we Link Pay to Performance," and contains the following:

> - **The core link** is performance measured across **5 key metrics** evaluated comprehensively within the context of our operating environment.
>
> - Core operating income
> - Core operating return on equity
> - Core operating return on tangible equity
> - P&C combined ratio
> - Tangible book value per share.
>
> (Id.; emphasis in original, and see Chubb's Invitation and Proxy Statement for the 2022 Annual General Meeting of Shareholders, May 19, 2022 (hereinafter, "Chubb's 2022 Proxy Statement," p. 5, same).[9]

22. Chubb then discusses what is called the "Compensation Profile."

> When determining the final pay mix to pay for the CEO and other NEOs [ ], the overall compensation package is weighted towards variable rather than fixed compensation, and to long-term rather than short-term awards, **in order to better link pay and performance and to align executive awards with long-term shareholder value creation.** In line with this approach, long-term equity compensation for our CEO and NEOs is typically 1.5 to 2.5 times the short-term annual bonus compensation award. (emphasis added)

23. The 2025 Proxy Statement section entitled "Our CEO Compensation Process" adds further relevant information to this analysis.

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[9] The third column, which is not discussed here, refers to the amounts of CEO and NEO compensation.

> Each year, the Compensation Committee sets a scorecard for the potential range of CEO compensation, with top-, middle,- and low-end bands ties to achievement of specific financial, operation and strategic goals, considered together with TSR, as reflected in the following summary for 2024:
>
> (Chubb 2025 Proxy Statement, p. 6).

24. Under the sub-heading, entitled "Financial Operational & Strategic Scorecard," the Financial Results column, which comprises 75%, includes among five factors, the "P&C combined ratio." (Id., and see p. 76, and see Chubb's 2021 Proxy Statement, p. 5, same, and see Chubb's 2022 Proxy Statement, p. 6, same).

25. Significantly, those eligible for the Long-Term Incentive Plan include the following:

> All employees and directors of Chubb or its subsidiaries, as well as consultants and other person providing services to Chubb or its subsidiaries, are eligible to become Participants in the Amended LTIP, except that non-employees may not be granted incentive stock options.
>
> (Chubb's 2021 Proxy Statement, p. 36).

26. The Purpose of the Amended Long-Term Incentive Plan is to

> - **Create a link between recent performance, compensation and the enhancement of long-term shareholder return**;
> - Motivate eligible individuals to whom awards under the Amended LTIP are granted (Participants), **by means of appropriate incentives**, to achieve long-range goals.
>
> (Chubb 2021 Proxy Statement, p. 34; emphasis added).

27. The foregoing plan is significant for two reasons. First, it establishes that employees, which include claim department employees, are provided stock ownership and cash incentive awards in Chubb through the Amended Long-Term Incentive Plan. (See Chubb's 2021 Proxy Statement, p. 9) Employees then have a direct financial interest in Chubb's profitability, which would include its combined ratio. Given that employee performance is linked to this compensation there is a direct motivation for claims department employees to handle claims to Chubb's benefit, not unlike what occurred in Chubb's handling of Pollock's claim.

28. It is equally important to note that Chubb apparently has plans to achieve certain combined ratio goals. For example, in Chubb's 2022 Proxy Statement it was noted that "P&C combined ratio performance was just below plan but improved from prior year and bettered each of our peers." (Chubb 2022 Proxy Statement, p. 10). Creating a plan to reduce or even keep level the combined ratio would be clearly contrary to insurance industry standards. Such a plan would create an artificial goal that had to be achieved regardless of number and cost of claims. Accordingly, claim department employees, in order to achieve the goal, and for Chubb to also achieve the goal, would have to be not only very aware of claim payments but also the amounts of those payments, as is demonstrated in Chubb's handling of Pollock's claim. This is because the only way for claims department employees to effectively reduce the combined ratio is to reduce or delay claim payments.

29. Second, the Amended Long-Term Incentive Plan benefit is also provided to "persons providing services to Chubb." This would include

consultants retained by Chubb to assist in Chubb's handling of claims. Such an arrangement has never been seen by this writer. This is probably because providing this benefit to consultants, experts, investigators or others who assist Chubb in the handling of claims, such as here, would create a clear conflict of interest between the consultant's obligation to objectively evaluate the claim on the one hand and the consultant's financial motivation to improve Chubb's stock value and therefore profitability.[10] (See Miller Report, pp. 60-61).

30. Chubb then reviews the company's performance against the Financial Performance Peer Groups. One of the peer groups is the 2024 Financial Performance Peer Group. This is a group of seven insurance companies, six of which have had and/or currently have extensive programs aimed at artificially reducing, delaying or denying claim payments, by measuring company performance against, among other factors, their combined ratios. The five companies are:

- The Allstate Corporation.
- American International Group, Inc. ("AIG")

[10] Insurers should diligently avoid even the appearance of bias on behalf of their consultants (See Zalma, Barry, Insurance Claim: A Comprehensive Guide, Vol. II [Nat'l. Underwriter Co., 1st ed., 2015], p. 923, "Reliance on an expert, on the other hand, will not automatically insulate an insurer from a bad faith claim based on a biased investigation if the insurer selects its expert in a way designed to avoid coverage rather than find truth"). Similarly, it is pointed out in the insurance industry text Claim Handling Principles and Practices that "claim representatives should work with service providers that are unbiased and have no conflict of interest. Courts and juries may not look sympathetically on medical providers or repair facilities that always favor insurers." (Claim Handling Principles and Practices, Popow, Donna J., ed. (The Institutes,1st ed., 2012) §9.26)

- Liberty Mutual Holding Company, Inc.
- The Hartford Financial Services Group, Inc.
- The Travelers Companies, Inc.
- Zurich Insurance Group.

(and see Chubb's 2021 Proxy Statement, p. 7).

31. It is noteworthy that the programs in these "Financial Performance Peer Group" companies are in several regards similar if not identical to Chubb's programs. There is the emphasis at Chubb, as with these other insurers, on the reduction of the combined ratio, tying personal performance to company financial performance, the providing of bonuses based on company financial performance, which is measured, in part, by improvement in the combined ratio and providing company stock to employees based on financial performance. The peer group companies and their similar programs are:

- The Allstate Corporation.

  See Berardinelli, J.D., et al., From "Good Hands" to Boxing Gloves: How Allstate Changed Casualty Insurance In America, " (Trial Guides, 2006), and see "Insurance Claim Delays Deliver Massive Profits to Industry By Shorting Customers," Huff Post, Dec. 13, 2011.

- American International Group, Inc. ("AIG")

  According to AIG documents, the "AIG Priorities for 2014," were "[g]rowth and profitability in our core insurance business" (AIG 2013 Form 10-K). The "AIG PROPERTY CASUALTY STRATEGIC INTIATIVES AND OUTLOOK" publication, also for 2014, as to "Claims Best Practices," included "lower[ing] the loss ratio" (Id.; emphasis in original). Similarly, in AIG's 2013 Form 10-K, the continued reduction of the loss ratio over "the past four years" was noted. This means that the claims handlers will be motivated to pay less than what is owed on claims. This is aptly demonstrated in AIG's own reserve reducing efforts. In

the article "AIG Profit Surges on Tax Benefit" (The Wall Street Journal, February 24, 2012), the following was pointed out:

> Operating income at AIG's property-casualty unit, Chartis, included a $13 million benefit from an adjustment to reserves. The positive mark stands in stark contrast to the fourth quarter of 2010, when Chartis took at $4.2 billion net reserve charge to reflect sharply higher claims estimates for insurance policies sold in previous years.
>
> . . .
>
> The combined ratio at Chartis was 107.3, meaning the company spent $1.07 on claims and expense for every dollar it collected in premiums. A year ago, the combined ratio was 160.5, reflecting the massive reserve charge.

AIG has also instituted stock investment plans that are inappropriate for any claims department operation. According to the American International Group, Inc., 2010 Stock Incentive Plan:

> The purpose of the American International Group, Inc. 2010 Stock Incentive Plan is to attract, retain and motivate officers, directors and key employees of American International Group, Inc. and its consolidated subsidiaries to compensate them for their contributions to the Company and to **encourage them to acquire a proprietary interest in the company**. (Emphasis added)

Providing an ownership connection to the company's successful profitability may be appropriate in certain insurance company departments, such as underwriting or sales, but it is contrary to the operation of a claim department. Claim department employees should not be provided any direct compensation based on the profitability of the company. Nonetheless, that is what AIG has done. Payment of stock shares to AIG claims department personnel has been confirmed (See deposition of Andrew Barnikel, in *Moses Taylor Hospital, Inc., et al. vs. Chamberlin & Reinheimer Insurers, et al*., Law Court, Lackawanna Cty., PA, Civ. Action No. 05-CV-4563 [hereinafter, "*Moses Taylor*"], p. 108; and see American International Group, Inc., 2013 Short-Term Incentive Plan). AIG has also set improper claims handling goals. Over a period of several years,

AIG has set annual claim payment reduction goals for its claims handlers (See deposition of Andrew Barnikel, in *Moses Taylor*, pp. 104–107). Such artificial claim payment reduction goals distort the claim handling process, in that they provide an incentive to claims handlers to seek to pay less than is owed on claims in order to meet the artificial goals.

- Liberty Mutual Holding Company, Inc.

Liberty Mutual has adopted performance measurements for its claims personnel which encourage them to either delay or pay less on claims. Indeed, in Liberty Mutual's January 2002 employee newsletter, *Life with Liberty,* John Connors, Liberty Mutual's Executive Vice President and Personal Market Manager, was quoted as saying that, "a good claims department can make or break a company's profitability." It is improper to evaluate claims professionals based on their contribution to company profits. Nonetheless, that is exactly what Liberty Mutual has done. According to Jay Anderson, Liberty Mutual's claims manager for property claims, Liberty Mutual used an annual performance evaluation process called the Objective Setting and Performance Evaluation Process ("OSPE").

Prior to the OSPE, Liberty Mutual used a Performance Planning and Review ("PP&R") process to review employee performance (Anderson deposition, in the matter of *James F. and Lisa O'Toole v. Liberty Mutual Insurance Company*, Sup. Ct., Maricopa Cty., AZ, Case No. CV2004-015042 [hereinafter, the "O'Toole Litigation"], pp. 56, 59).[1] Anderson was involved in training Liberty Mutual employees on the implementation of the PP&R process (Id., p. 82). The PP&R process would have been in effect since at least 2002 (Id., p. 59). Anderson confirmed that the purpose of the PP&R process was to move to a more objective measurement of performance, and to include pay for performance as part of the review process (Id., pp. 82–83). According to Anderson, claims managers like himself received their annual goals in the form a letter from the home office (Anderson deposition, pp. 98–99). For example, Liberty Mutual's financial performance in relation to claim severity for building and personal property claims was one of the goals that were included in his annual review (Anderson deposition, pp. 45–46). Severity is defined as the median cost of all claims (Id., p. 46). Anderson had annual claim severity goals (Id., p. 51). These goals are apparently set by Liberty

Mutual's home office (Id., p. 59). Anderson further testified that his job was to ascertain how to manage the claims employees under his supervision to meet his goals (Id., p. 55). For example, in an annual PP&R for Kelly Greenlee, a Liberty Mutual claims department employee, one of her business objectives was to "control property loss payments" (Id., p. 102). According to Anderson, this meant that, annually, Liberty Mutual made sure that property loss payments were within his goals (Id., pp. 102–103).

The objective criteria used to evaluate how the claims operation was controlling property loss payments was called pure premium, which is the total amount paid on claims, exclusive of claims expenses, divided by the number of homes insured by Liberty Mutual (Id., pp. 103–104, 121). A reduction in pure premium would tend to be good for Liberty Mutual (Id., p. 123). The measurement of pure premium operates the same as the measurement of average paid claims. They are both used to measure company profitability. Indeed, Mark Parabicoli, Liberty Mutual's Managing Director of Auto and Home Voluntary Benefits Programs, testified that pure premium is "a complex profitability metric that was calculated in a management information group" (Deposition of Mark Parabicoli in the O'Toole Litigation, p. 187). With a severity measurement, the total amount paid on claims is divided by the number of claims, whereas with the pure premium measurement, the total amount paid on claims is divided by the number of insured households. In both cases, the focus of the measurement is on the total amount paid on claims, which is then divided by a factor to obtain an average payment of claims. The claims handler is then given an artificial goal of reducing their average payment on claims. The pure premium measurement provides the same improper measurement of claims operations as claims severity does.

In addition to controlling loss payments, Team Managers were evaluated on their contribution to the region's profitability (Id., p. 109). It is improper for an insurer to require its claims representatives to reduce their average paid claims, as Liberty Mutual has done, because it imposes on the claims representative an artificial financial goal that has no relationship to the actual value of the claim, and thus results in claims payments that are below the full claim value. On the other hand, by requiring a reduction in average paid claims, Liberty Mutual does contribute to its overall profitability. Accordingly, any goal which has as its objective the reduction of average paid claims will have the effect of reducing claim payments, thereby improving the insurance company's combined ratio and

its profitability. Anderson testified that he also receives monthly reports from Liberty Mutual's Management Information Group on claims severity, which are broken down into three brackets (Id., pp. 47–48).

Claims management provides information on claim severity on a quarterly basis to Liberty Mutual's Team Leaders (Id., p. 49). Claims managers, such as Anderson, supervise the Team Leaders, whereas the Team Leaders supervise the claims representatives (Id., p. 101). These reports are a further indication that Liberty Mutual claims management improperly monitored average paid claim performance of its claims employees. In addition, Liberty Mutual has also measured claims employee performance based on the employee's ability to reduce leakage (See Tres Robertson PP&R, "[a]chieve CFR leakage objectives. Use results from the CFR program and Quality Assurance," Bates No. LM 19494; and Gilbert C. Bihn PP&R, "[a]s we move forward loss and expense leakage will become an even greater measure upon which our success or failure to determined," Bates No. LM 19687).[1] In the insurance industry, "leakage" is the subjective measurement of what the insurer believes is overpayment on claims.[1] This measurement creates another artificial goal for the claims adjuster. The claims adjuster has to meet this artificial goal by reducing claim payments, regardless of the merits of the claim.

In addition to the foregoing goals, since at least 2001, Liberty Mutual also had a combined ratio goal for its regions. Any goal which has as its objective the reduction of the combined ratio will have the effect of reducing claim payments. Liberty Mutual has significantly reduced its combined and loss ratios between 1990 and 2012. Liberty Mutual itself has pointed to its success in reducing its combined ratio. In Liberty Mutual's 2013 Annual Review, it is noted that, between 2012 and 2013 Liberty Mutual Insurance Group reduced its combined ratio from 104.8 to 99.8%. This reduction in the following year was also reported in Liberty Mutual's 2014 Annual Review, where it was reported that Liberty Mutual had reduced its combined ratio down to 97.5%.

One of Liberty Mutual's bonus programs, the Variable Incentive Plan ("VIP"), provides annual cash bonus awards to individual employees, including claim department employees. The bonus awards are based, in part, on the company's financial success. The profit orientation of the VIP program is evident in Liberty Mutual's own document, entitled "Compensation," where, under the heading, "You can Make a Difference," it is stated that the Variable Incentive Plan "provides a cash award based on how

much you and your business unit contribute to the Company's financial success." Liberty Mutual employees, including claims department employees, are periodically made aware of the company's financial performance (See deposition of David Digan, in the matter of *Jami Cooper and Sharon Cooper v. Liberty Mut. Ins. Co., et al.*, Dist. Ct., Tulsa Cty., OK, Case No. CJ-2006-2002, pp. 23–25). According to these same Liberty Mutual documents, claims department employees can earn up "to 12.5% of base salary when you meet your annual performance objectives and your Strategic Business Unit (SBU) meets its earnings target" ("Compensation," p. 4-3). Accordingly, the claims department can readily determine the impact their own claims handling is having on corporate profitability, and thereby their eligibility for a bonus.

- The Hartford Financial Services Group, Inc.

See "Insurance adjusters rewarded for shrinking claims checks," Fey, Joe, Insure.com

- The Travelers Companies, Inc.

Beginning in at least 2000, Travelers put into place its Claim Total Compensation Program (hereinafter, the "Compensation Program").[1] A major theme of the Compensation Program was to pay Travelers' claims employees for achieving "critical operating results." Included within this Compensation Program were two variable incentive programs: the Claim Professional Incentive Plan (hereinafter, the "CP Plan") and the Property Casualty Claim Incentive Plan (hereinafter, the "P&C Plan"). All regular claims employees above salary grade 65 were eligible for the P&C Plan, and "[r]egular employees in certain claim professional positions" were also eligible for the CP Plan.[1] In other words, most (if not all) of Travelers' claims employees were eligible for either the CP Plan or the P&C Plan. Funding for both the P&C Program and the CP Plan was based, in part, on the success of the claims department in reducing the "previous year's Claim payout."

Travelers' Compensation Program may have continued through at least 2005, with some changes. As pointed out, however, in *Linda Leonard v. The Travelers Indemnity Company,* Dist. Ct., Galveston Cty., TX, 405 Judicial District,

Cause No. 05CV0149 (hereinafter, the "Leonard Action"), the Compensation Program continued to contain improper claims goals. According to Plaintiff's Motion to Compel Compliance with Court Order Requiring Knowledgeable Corporate Representatives, filed in *Leonard*, Travelers continued to provide its claims employees with incentive bonuses through 2005. These bonuses were based upon a group of measurements, which are included on what is called the "scorecard." One of these measurements includes "average paid value on claims." This performance measurement applies to "everybody," and to "all" of Travelers' claims. Indeed, profit goals also apply to Travelers underwriters. According to Kevin Cahill, who was deposed in *Leonard*, the underwriter's bonuses would be based, at least in part, on the profitability of his or her book of business, which would be determined, in part, by the claims paid under the coverages the underwriter had written.

Given the bonus and equity compensation programs that Travelers has adopted, a reduction in Travelers' loss ratio would be expected, along with a corresponding reduction in its combined ratio. Such a reduction would directly improve Travelers' profitability. This improvement in profitability is aptly demonstrated in the significant improvement in the combined and loss ratios for Travelers Indemnity Company since 2000. Since 2003 (and up to 2010), Travelers Indemnity Company's loss ratio has been less than the industry average and has shown a consistent downward trend. Indeed, during that period, the loss ratio has not reached pre-2003 levels. Likewise, Travelers Indemnity Company's combined ratio has also shown marked improvement from pre-2003 levels. Clearly, Travelers Indemnity Company has been able to significantly reduce its claims payments between 2003 and 2010.

- Zurich Insurance Group.

Zurich has a "Short Term Incentive Plan" ("STIP"). According to the 2010 STIP "Description for Participants"

> The Short Term Incentive Plan ("STIP" or "the Plan") reinforces the Performance Management philosophy which links the business performance with individual performance.
>
> …

> The STIP is designed to motivate, focus and reward our people for successfully achieving specific organizational and individual performance objectives.
>
> …
>
> Business targets are defined by the Zurich Financial Services Group ("Zurich") at the start of the financial year. At year end, Zurich ascertains and assesses actual business performance on the basis of the key performance metrics.
>
> …
>
> The distribution of the Actual STIP Pool to participants will then take into account the performance of the relevant Business Unit, including achievement of key financial plan metrics such as growth goals, and the participants' relative individual performance contribution to the overall results.
>
> …
>
> The individual target award for each STIP participant is calculated as a percentage of the gross salary.
>
> …
>
> Actual individual awards will be determined based on relative business and individual performance within the overall pool funding…

Accordingly, insurers, such as Zurich, that institute compensation and bonus programs that are related to the company's financial performance, such as STIP, will provide their employees, including claim department employees, a powerful incentive to achieve the company's financial goals, even to the detriment of the company's insureds.

32. The similarity of these programs cannot be overlooked, as they demonstrate, as has been acknowledged elsewhere,[11] that in the highly competitive nature of the insurance business insurers will be aware of their competitors' actions to improve their competitive position, thereby providing a strong incentive for other insurers to do the same.[12]

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[11] See Miller, Charles, "Behind the Scenes in the Insurance Claims Industry: How Insurance Companies Have Revolutionized Claims Handling, an Update," Forum (Vol. 46, Number 1, Jan/Feb. 2016), p. 22, and see Miller, Charles M., "Behind the Scenes in the Insurance Industry: How Insurance Companies Have Revolutionized Insurance Claims Handling" Forum, Vol. 37, No. 6, July/August 2007.

[12] Insurers share information regarding their claims handling policies and procedures including the development and implementation of incentive and pay for performance programs. In the mid-1980s, USAA consulted with McKinsey & Co. regarding a redesign of USAA's claims operations. Subsequently, USAA invited many other insurers to its headquarters in San Antonio, Texas, in order to share with them the results of USAA's claims department redesign. As part of its claims department redesign, USAA also sent representatives to State Farm's Bloomington, Illinois, home office to interview personnel in State Farm's General Claims Department. Other State Farm claim officials shared results and methods with USAA regarding methods of handling catastrophic property losses. (deposition of William Hutton in the matter Byron N. Kenyon and Peggy Kenyon v. United Services Automobile Association, Sup. Ct., AK, Third Jud. Dist. at Anchorage, Case No. 3AN-89-7667 Cl.) Subsequently, State Farm hired McKinsey & Co. to redesign State Farm's claims operation. This collaboration resulted in the State Farm program, "Advancing Claims Excellence." Indeed, many insurers have consulted with McKinsey & Co., and similar consulting companies, regarding their claims operations. As a result of these consultations, McKinsey has helped these insurers put into place claims department programs and procedures very similar to those McKinsey put into place at State Farm. The following was noted in one State Farm publication:

a. Was ACE developed in-house?

No, McKinsey, outside consultant, helped develop methodology but we helped on PD side.

b. Is McKinsey selling the program to other companies?

33. Chubb believes that "the Financial Performance Peer Group is the most relevant peer group to compare to the financial performance of the Company on core operating income, core operating return on equity, core operating return on tangible equity, **P&C combined ratio** and tangible book value per share growth, as well as TSR." (2022 Chubb Proxy Statement, p. 86; emphasis added, and see Chubb's 2024 Proxy Statement, p. 109). Given that the financial performance of most of the peer group is driven, at least in part, by various pay for performance programs designed to artificially delay, deny or fail to pay insurance claims, Chubb's comparison to this group cannot ignore how the peer group achieved its own goals. The fact the peer group companies (including ACE) have adopted pay for performance programs would, in and of itself, be a strong incentive for Chubb to do the same.

34. Given these programs at Chubb, it is not surprising that Chubb has consistently experienced low combined ratios as compared to the industry.

> They have issued this methodology with other companies.
>
> (June 12, 1995 State Farm Questions & Answers DCS Conference, June 5-9, 1995).

Similarly, Martin Feinstein, former CEO of Farmers Group, Inc., made a presentation to Farmers' employees called "Claims Vision." In that presentation, Mr. Feinstein stated that Farmers' employees visited several other insurers to talk to them about how they ran their claims operations. (See transcript and video of the Farmers Group Inc. videotape, "Claims Vision" in which Martin D. Feinstein, Farmers Chairman of the Board, CEO and President, made a presentation to Farmers' state executives on Farmers Operation Restore Claims program).

Indeed, Chubb points out that in 2024 it had a "[i]ndustry-leading P&C combined ratio of 86.6% nearly matching 2023's record of 86.5%. The current accident year P&C combined ratio excluding catastrophic losses was a record of 83.1% compared to 83.9% in 2023." (2025 Chubb Proxy, p. 7, and see Chubb's 2022 Proxy Statement, p. 80, "Industry-leading P&C combined ratio of 89.1% in 2021 compared to 96.1% in 2020"). Indeed, Chubb's "P&C combined ratio relative performance was better than that of every company in the Financial Performance Peer Group (100th percentile)." (Id. at p. 9, and see Chubb's 2021 Proxy Statement, p. 8, documenting Chubb's continuing lower combined ratio as compared to the Financial Peer Group from 2004 to 2020, and p. 9, and see Chubb's 2022 Poxy Statement, p. 9, same). Further, from 2020 to 2024, Chubb succeeded in substantially reducing its combined ratio from 96.1% in 2020 to 86.6% in 2024. (Chubb's 2025 Proxy Statement, pp. 107 & 109).

35. For the years 2015 to 2019, the combined ratio ranged from 87.2% in 2015 to 90.6% in 2019. Significantly the "loss and loss expense" ratio during this time was 58.1% in 2015 and 62.1% in 2019. (2019 10-K, p. 34).

> In reporting the performance of an underwriting and risk-taking company, the most important line on the P&C insurance scorecard is the published combined ratio, which measures underwriting profitability. Ours was 86.6% in 2024 and has averaged 86.9% over the past three years, a gold standard among insurers globally. No matter what time period you pick – three, 10 or 20 years – we have outperformed our peers and the industry generally by eight to nine percentage points. On a current accident year basis excluding catastrophe (CAT) losses, a secondary measure that looks through catastrophe-related volatility to current period results, our combined ratio last year was 83.1%. Our advantage is not simply in our underwriting. It's also our operating efficiency. We run an

> expense ratio of 26.2%, and this is a meaningful and enduring advantage.

36. The combined ratio is uniquely important in evaluating an insurer's profitability. It has been noted that,

> A critical component of underwriting effectiveness for insurance companies is the combined ratio, which is a measure of profitability used by insurance companies to reflect the operation efficiency of the business.
>
> The combined ratio…is perceived as a better measurement of management and underwriting efficiency as compared to overall profit or loss for business. Chubb's property and casualty combined ratio for the trailing 12 months ending March 31 [2024] averaged 87.10% versus ….97.10% for the industry as a whole
>
> ("A Closer Look at Berkshire Hathaway's Chubb Investment," by GuruFocus, *Forbes, July 5, 2024 (hereinafter, "Forbes").*

37. Further, Chubb's Limited 2024 Letter to Shareholders advised the Shareholders of the following:

> P&C Combined Ratio Versus Peers
>
> The company's underwriting results have outperformed the average of its peers over the last 20 years.
>
> [1]Includes AIG, ALL, CNA, HIG, Liberty Mutual Group, and TRV
>
> Combined ratio measures the underwriting profitability of our property and casualty business. **P&C combined ratio and Current accident year (CAY) P&C combined ratio excluding catastrophe losses (Cats)** are non-GAAP financial measures. Refer to the Non-GAAP Reconciliation section in the 2024 Form 10-K, on pages 66-69 for the definition of these non-GAAP financial measures and reconciliation to the Combined ratio.
>
> Combined ratio measures the underwriting profitability of our property and casualty business. **P&C combined ratio**

and Current accident year (CAY) P&C combined ratio excluding catastrophe losses (Cats) are non-GAAP financial measures. Refer to the Non-GAAP Reconciliation section in the 2024 Form 10-K, on pages 66-69 for the definition of these non-GAAP financial measures and reconciliation to the Combined ratio.

	Full Year 2024	Full Year 2023
Combined ratio	86.6%	86.5%
Add: impact of gains and losses on crop derivatives	0.0%	0.0%
P&C combined ratio	86.6%	86.5%
Less: catastrophe losses	5.5%	4.5%
Less: prior period development	-2.0%	-1.9%
CAY P&C combined ratio excluding Cats	83.1%	83.9%

Table presents the reconciliation of combined ratio to P&C combined ratio, and the reconciliation of P&C combined ratio to CAY P&C combined ratio excluding Cats:

The following table presents the reconciliation of combined ratio to P&C combined ratio, and the reconciliation of P&C combined ratio to CAY P&C combined ratio excluding Cats:

	Full Year 2024	Full Year 2023
Combined ratio	86.6%	86.5%
Add: impact of gains and losses on crop derivatives	0.0%	0.0%
P&C combined ratio	86.6%	86.5%
Less: catastrophe losses	5.5%	4.5%
Less: prior period development	-2.0%	-1.9%
CAY P&C combined ratio excluding Cats	83.1%	83.9%

38. Chubb has a combined ratio lower than the industry's and well below the 100 break even point. Chubb, therefore, is making a significant underwriting profit. As noted supra, the only way for the claims department to significantly impact the combined ratio is by reducing or delaying the payment of claims. This means that senior management must communicate corporate goals and objectives, such as the reduction of the combined ratio, to Chubb's claims department. This can be accomplished in three ways.

39. First, and as with pay for performance programs at other insurance companies, Chubb links its financial performance directly to the salaries and bonuses of its executives.

> Compensation decisions reflect the Company's philosophy to closely link pay to performance ensuring that its leadership team remains highly motivated and strongly aligning remuneration with the creation of shareholder value.
>
> (Id. at p. 10).[13]

40. Providing the financial motivation to claims management to achieve important company goals, such as the reduction of the combined ratio, is likely to lead to significant success. Indeed, that is exactly what Chubb has experienced with its market leading combined ratios.

41. But the motivation of management and supervision is only one step in this process. The second step is the recognition that achieving company

[13] Likewise, Chubb writes that the "goal of our compensation program is to fairly compensate our employees and to enhance shareholder value by closely aligning our executive compensation philosophy and practices with the interests of our shareholders." (Id. at p. 41)

goals and objectives are principal functions of claims management and supervision. As one insurance industry author has noted:

> Effective claim management often depends on the effectiveness of the front-line claim supervisors, who must train, guide, and develop the claim representatives who deliver on the promise contained in the policy…. Supervisors are the front-line management of the claim department. They are the first line of defense against sloppy or incompetent claim handling. Thus, they must have systematic ways to review the claim file handling by claim representatives. They cannot rely on claim representatives to bring every problem file to them because claim representatives may be too busy or might want to suppress bad news. Supervisors must thus periodically review staff claim files.
>
> (Markham, p. 318).

42. Goals, such as the reduction of the combined ratio, are achieved not by senior management in and of themselves. Indeed, that would not be possible. Rather management and supervision must assure that front line claims handlers are handling claims in concert with company goals.

43. Indeed, it was noted in the 2025 Chubb Proxy Statement that John W. Keogh, Chubb's President and Chief Operating Officer's 2024 Performance Criteria included "overall Company performance, against both financial and strategic objectives and his strategic leadership of Chubb's general insurance business units as well as the product, underwriting, **claims** and support functions globally." (Chubb's 2025 Proxy Statement, p. 93; emphasis added). As a result of his performance his annual cash bonus was increased 12.7% and his 2024 total direct compensation as increased 10.9%. (Id.).

44. Keogh's performance was measured, in part, based on Chubb's combined ratio. His "strategic leadership" of claims would mean that he would have direct involvement in assuring that company goals, such as the reduction of the combined ratio, was implemented in the claims department.

45. Third, providing financial incentives to employees, including claim department employees, to achieve certain goals, such as reducing the combined ratio. (See Supra). Indeed, Scott Robinson acknowledged that a claims adjuster's performance review is based, in part, on the loss ratio. (Robinson deposition, pp. 251-252).

46. The effect of Chubb's emphasis, in many ways, on the reduction of its combined ratio, and thereby the reduction in claims payments is clearly demonstrated in the report of Kevin E. Cahill in this case.

47. Cahill, in his March 26, 2025 report, concludes, following an extensive analysis, that "federal's payments for covered losses are lower than what would be expected given actual losses from the Glass Fire." (Cahill Report, p. 4). He further found that "the percentage of coverage paid for unburned structures would need to be increased substantially in order for Federal's payments to be in line with the actual data from the Glass fire." (Id. p. 5, and see p. 13, "Federal's payments for covered losses are, therefore, lower than what would be expected based on actual data from the Glass Fire.").

48. There is substantial evidence in Chubb's handling of Pollock's claim that Chubb sought to put its own financial interests above those of Pollock.

(See Miller Report generally). A startling example of this conduct is Chubb's failure to timely post a reserve on the claim. As noted in the Miller Report, even though Pollock's claim arose in 2020, by March 2024 a reserve had still not been posted on the claim. (Miller Report, pp. 36-38).[14] This inured directly to Chubb's benefit and its goal of reducing the combined ratio.

49. This conduct is particularly egregious given the substantial State regulation of insurer reserving practices. The California Insurance Code provides:

> (a) Every insurer shall immediately establish an effective method for testing the adequacy of loss and loss expense reserves previously established and reported in the annual statement.
>
> (b) Such method shall include provision for the estimation of the current adequacy level.
>
> (c) Such method must be adequately described and shall include a description of the insurer's claim practices to the extent that they affect the data used in the reserve test method. Such description shall include, among other things, the definition of a late-reported claim, the definition of a reopened claim, changes in claim practices, the procedures used to verify that the tabulation of outstanding claims at a given date contains all of the files of open claims as of such date, and other pertinent information. This description is to be continuously updated and immediately available to the Commissioner on request.

[14] It appears that Chubb did not post a reserve because the claim "is in litigation." (Bates Nos. Chubb_95669). In the insurance industry, the fact that a claim is in litigation is not justification for not posting a reserve. Indeed, Chubb did not post a reserve even before the matter went into litigation.

> (d) Such method shall provide a means of testing as of June 30 the adequacy of each calendar year's reserves previously established.
>
> (e) The data must be fully reconcilable to annual statement type data.
>
> (f) If a material deficiency is indicated by the reserve test method for the reserves as established, the insurer shall take corrective action prior to the preparation of the next subsequent annual statement.
>
> (g) Such method shall also separately estimate the deficiencies in the reserves for reported claims.
>
> (10 CCR §2319.1).

50. Pursuant to the foregoing, Chubb would have had to review its reserves before June 30 of each calendar year. Accordingly, those reviews, following the fire damage to Pollock's property, would have had to occur in 2021, 2022 and 2023, and possibly in 2024. In Chubb's review in each of those years there would be no reserve posted on Pollock's claim. Accordingly, Chubb would not have been able to test the adequacy of the reserve on Pollock's claim, contrary to the requirement in the California State Insurance Code. It would be as if there was no Pollock claim.

51. Chubb recognizes that it is obligated to post reserves:

> As an insurance and reinsurance company, we are required by applicable laws and regulations and GAAP to establish loss and loss expense reserves for the estimated unpaid portion of the ultimate liability for losses and loss expense under the terms of our policies and agreements with our insured and reinsurance customers.
>
> (2019 10-K, p. 40).

52. Chubb's failure to post a reserve also appears to be contrary to Chubb's own requirements. As pointed in Chubb's December 31, 2019, Form 10-K ("2019 10-K"),

> We establish reserves for unpaid loss and loss expenses, which are estimates of further payments on reported and unreported claims for losses and related expenses, with respect to insured events that have occurred. These reserves are recorded in Unpaid losses and loss expenses in the Consolidated balance sheets….Internal actuaries regularly analyze the levels of loss and loss expense reserves, taking into consideration factors that may impact the ultimate settlement value of the unpaid losses and loss expenses. These analyses could result in future changes in the estimates of loss and loss expense reserves or reinsurance recoverables and any such changes would be reflected in our results of operations in the period in which the estimates are changed…
>
> For each product line, management, after consultation with internal actuaries, develops a "best estimate" of the ultimate settlement value of the unpaid losses and loss expenses that it believes provides a reasonable estimate of the required reserve. We evaluate our estimates of reserves quarterly in light of developing information.
>
> (2024 10-K, p. 12).

53. Accordingly, reserves posted in Pollock's claim should have been available to Chubb's management from 2021 to 2024 so the above analyses and estimates could take place. This did not happen with the Pollock claim as would be required under Chubb's practices. Again, it would be as if the Pollock claim did not exist.

54. As further noted in the Miller Report, Chubb's failure to post a reserve on Pollock's claim would have further served to artificially improve Chubb's combined ratio for each of the three, and possibly four, years following

the fire. It is nearly inconceivable that Chubb's failure to timely post a reserve would have gone unnoticed for nearly four years. Insurer's commonly have internal procedures and policies aimed at assuring that reserves are timely posted and are as accurate as possible. There appears to be no reasonable explanation for Chubb's failure to timely post the reserve.

55. Chubb's failure to [timely] post a reserve for the Pollock claim is but a part of Chubb's failure to post sufficient reserves for wildfire losses generally. According to Brian M. Carl, following his extensive study,

> Federal's estimated share of Chubb's Catastrophic Loss Charge for U.S. wildfires in its North America Personal P&C Insurance business of $162 million (i.e., Federal's approximately 22% share of Written and Earned Premiums in Chubb's Homeowners Multiple Peril line of business) is less than the lowest lower bound of Federal's potential exposure from the 2020 Glass Fire and other U.S. wildfires with or without the potential appraisal award [footnote omitted] in the pending litigation, which may be subject to prejudgment interest.
>
> (Carl Report, p. 23).

56. Federal's failure to post reserves in the Pollock case coupled with Federal's failure to post a sufficient Catastrophic Loss Charge means that Federal will most likely experience loss payments in excess of its posted reserves and Loss Charge. As a result, Federal will either have to increase its reserves and Loss Charges and/or seek to reduce claim payments in order to meet its original Loss Charge goals. As the foregoing strongly indicates Federal has chosen, at least in part, to seek to reduce its loss payments below those that would be expected. This will mean that Federal's combined ratio will likely be less than would otherwise be the case inuring to the financial benefit of

those whose bonuses and compensations are based, at least in part, on the combined ratio.

57. In addition to lowering the combined ratio, it has been recognized that insurers can improve their profitability through the investment of the float. As one author has pointed out:

> [E]arnings on funds reserved for claims is the most significant component of earnings for a property-liability insurance company. In banking, such funds are called 'float.' Besides the interest rate, the benefits of float depend on two things. First, they depend on how long the float is—how long the premium funds are held before being paid as claims, for that is how long the money can be kept invested. Second, the benefits depend on the cost of the float—the losses and expenses in obtaining it [(Buffet, 1994, p. 13; Buffett, 2000, p. 9; Stewart, 1979, p. 111)]. **Insurance managements are more than sufficiently intelligent to see that delaying the payment of claims increases the float period and denying claims decreases the cost**"
>
> ((“The Loss of the Certainty Effect,” Stewart, Risk Management and Insurance Review, 2001, Vol. 4, No. 2, p. 32; emphasis added).

58. This becomes particularly important given the substantial investment by Berkshire Hathaway in Chubb. (*Forbes,* p. 1). Warren Buffet has frequently acknowledged the importance of using the float to improve company profits.

> Warren Buffett's latest annual letter to Berkshire Hathaway shareholders is out.
>
> The letter also has a useful explanation of "float," an idea that's at the core of Berkshire's success, and that's central to the way the insurance industry works. In short, float is the money that an insurance company gets to hold onto between the time customers pay premiums and the time they make claims on their policies.

> Here's Buffett on the float:
>
> Insurers receive premiums upfront and pay claims later. ... This collect-now, pay-later model leaves us holding large sums -- money we call "float" -- that will eventually go to others. Meanwhile, we get to invest this float for Berkshire's benefit. ...If premiums exceed the total of expenses and eventual losses, we register an underwriting profit that adds to the investment income produced from the float. This combination allows us to enjoy the use of free money -- and, better yet, get paid for holding it.
>
> (Warren Buffett Explains The Genius Of The Float : Planet Money ...https://www.npr.org/sections/money/2010/03/warren_buffett_expla...1 of 8 7/26/2019, 1:22 PM).

59. Likewise, it has been noted that "[f]or Buffett, the thrill of accumulating float could be equated to being a kid in a candy store. Essentially, float is a free loan. As stated in Berkshire Hathaway's 2023 annual report,

> *"If our premiums exceed the total of our expense and eventual losses, our insurance operation registers an underwriting profit that adds to the investment income the float produces. When such a profit is earned, we enjoy the use of free money—and, better yet, get paid for holding it."*
>
> (Forbes, p. 4, emphasis in original).

60. It appears that Buffet's emphasis on the float will figure large in Chubb's operations. As noted, "Chubb stands to benefit from the combined forces of both its own leadership and diversified operations and those of Berkshire Hathaway's while navigating the continued hard market." (*Forbes, P. 10).*

61. Chubb's handling of Pollock's claim is clearly consistent with the goal of using the float to improve Chubb's profits. As noted in Miller's Report, Chubb continually and improperly delayed and denied payment of Pollock's

claim. Further, Chubb provided incentives to under pay claims, similar to several insurance companies against whom Chubb rates its own performance, and based on the analyses cited herein and in the Miller Report that has occurred in this matter. Further, Chubb failed to post a reserve on Pollock's claim thereby further improving its profits. This would assure Chubb that it would have the advantage of the float for much longer than would otherwise be the case.

C. CONTRARY TO INSURANCE CLAIMS HANDLING STANDARDS CHUBB FAILED TO TIMELY IDENTIFY, INVESTIGATE AND REPORT THE ALLEGED INSURANCE FRAUD BY POLLOCK.

62. The State of California has created extensive requirements for the investigation and evaluation of insurance fraud by insurance companies. The State Insurance Code provides in pertinent part:

> 1875.20. Every insurer admitted to do business in this state, except those otherwise exempted in this code, shall provide for the continuous operation of a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds.
>
> 1875.21. Insurers may maintain the unit or division required by this article using its employees or by contracting with others for that purpose.
>
> 1875.23. For purposes of this article, "unit or division" may include the assignment of fraud investigation to employees whose

> principal responsibilities are the investigation and disposition of claims. If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this article, the additional cost incurred shall be included as an administrative expense for ratesetting purposes.

63. In furtherance of the statutory requirements the California Department of Insurance ("DOI") has adopted equally extensive regulations regarding an insurer's anti-fraud efforts. These include the establishment, pursuant to the Insurance Code, of Special Investigated Units (SIU) to investigate fraud. SIUs are defined as:

> "Special Investigative Unit" (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be comprised of insurer employees or by contracting with other entities for the purpose of complying with applicable sections of the Insurance Frauds Prevention Act (IFPA) for the direct responsibility of performing the functions and activities as set forth in these regulations.
>
> (10 CCR §2698.30(p)).

64. The DOI's regulations also require that the SIUs are staffed with qualified personnel.

> (a) Adequacy. The adequacy of an insurer's SIU staffing shall be determined by its demonstrated ability to establish, operate and maintain an SIU that is in compliance with these regulations. Factors that may be considered in staffing the SIU include, but not limited to, the number of policies written and individuals insured in California, number of claims received with respect to California insureds on an annual basis, volume of suspected fraudulent California claims currently being detected and other factors relating to the vulnerability of the insurer to insurance fraud.

> (b) Knowledge. An SIU shall be composed of employees who have knowledge and/or experience in general claims practices, the analysis of claims for patterns of fraud, and current trends in insurance fraud, education and training in specific red flags, red flag events, and other criteria indicating possible fraud. They shall have the ability to conduct effective investigations of suspected insurance fraud and be familiar with insurance and related law and the use of available insurer related database resources.
>
> (10 CCR §2698.32(a) & (b)).

65. The DOI regulations also address the referral of suspected fraud claims to the SIU.

> (a) An insurer's integral anti-fraud personnel[15] are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.
>
> (b) The SIU shall establish, maintain, distribute, and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document, and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer. The red flags listed pursuant to the immediately preceding sentence shall be specific to each line of insurance, or each insurance product, transacted in or issued by the insurer.
>
> (c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against red flags and other criteria that may

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[15] "Integral anti-fraud personnel" includes insurer personnel who the insurer has not identified as being directly assigned to its SIU but whose duties may include the processing, investigating, or litigation pertaining to payment or denial of a claim or application for adjudication of claim or application for insurance. These personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties.

indicate possible fraud.

(10 CCR §2698.35(a)-(c)).

66. SIUs are directed to develop procedures for the investigation of insurance fraud as well as conduct extensive investigations of insurance fraud.

> (a) The SIU shall establish, maintain, distribute, and adhere to written procedures for the investigation of possible suspected insurance fraud. An investigation of possible suspected insurance fraud shall include:
>
> (1) A thorough analysis of a claim file, application, or insurance transaction, that includes consideration of factors indicating insurance fraud.
> (2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.
> (3) Utilizing one or more industry-recognized databases identified by the SIU as appropriate for use in fraud investigations involving the particular line of insurance in question.
> (4) Preservation of documents and other evidence obtained during an investigation.
> (5) Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, is separate from any other document prepared in connection with the investigation, and includes the investigators' findings regarding the suspected insurance fraud and the basis for their findings. The summary shall answer the following questions:
> (A) What facts caused the reporting party to believe insurance fraud occurred or may have occurred?
> (B) What are the suspected misrepresentations and who allegedly made them?
> (C) How are the alleged misrepresentations material and how do they affect the claim or insurance transaction?
> (D) Who are the pertinent witnesses to the alleged misrepresentation, if there are pertinent witnesses?
> (E) What documentation is there of the alleged misrepresentation, if documented?
> (F) In addition, the summary prepared pursuant to this subdivision (a)(5) shall include a statement as to whether

> or not the investigation is complete.
>
> (b) Each investigation of suspected insurance fraud shall include performing at least the procedures specified pursuant to subdivision (a) of this Section 2698.36, to the extent they are applicable.
>
> (c) The SIU shall investigate each credible referral of suspected insurance fraud that it receives from integral anti-fraud personnel, including automated or system-generated referrals. A credible referral of suspected insurance fraud is one that includes a red flag or red flags. However, the first sentence of this subdivision (c) notwithstanding, in the event that upon a preliminary review the SIU determines that it is reasonably clear that the red flag or red flags contained in the referral is not or are not the result of suspected insurance fraud, the SIU need not open an investigation. In the event that the SIU refrains from opening an investigation pursuant to the immediately preceding sentence, the SIU shall document in the claim file or SIU investigation file the reasons supporting its conclusion that the red flag or red flags contained in the referral is not or are not the result of suspected insurance fraud.
>
> (10 CCR§2698.36(a)-(c)).

67. The DOI Regulations also address the referral by SIUs of suspected insurance fraud to the DOI.

> (a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and, as required, district attorneys.
>
> (b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.
>
> (c) Referrals shall be made within the period specified by statute.
>
> (d) The SIU shall complete as much of its investigation as is reasonable prior to the time the referral is made to the Fraud Division. Each referral of suspected insurance fraud shall indicate whether the investigation is complete or further investigation is needed.

A referral of an act of suspected insurance fraud to the Fraud Division shall be legible and on a form as directed by the Department and contain the information and data to the extent applicable, as provided in the following:

(a) Fraud and referral type

(1) Fraud type

(2) New referral/amended referral indicator

(b) Reporting party information

(1) Two-digit reporting party code, as follows:

(A) Carrier/licensed insurer:.....

(B) Private sector self-insured:.....

(C) Public sector self-insured:.....

(D) Third party administrator:.....

(E) State Compensation Insurance Fund (SCIF):.....

(2) Reporting party name

(3) Reporting party California Certificate of Authority number

(4) Reporting party self-insured or contracted third party license number, as appropriate

(5) Reporting party address, city, state, and zip code

(6) Reporting party email address (generally, contact address)

(7) Reporting party Federal Employer Identification Number

(c) Alleged victim information, as appropriate

(1) Alleged victim company name

(2) Alleged victim California Certificate of Authority number

(3) Alleged victim self-insured or contracted third party license number, as appropriate

(4) Alleged victim address, city, state, and zip code

(d) Insurance policy or claim information, as appropriate

(1) Claim number associated with referral

(2) Insurance policy number associated with referral

(3) Date of loss or injury

(4) Geographic location where loss or injury occurred

(5) Insurance premium dollar loss

(6) Total potential loss on claim prior to the identification of fraud

(7) Total claim loss paid to date

(8) Actual suspected fraudulent loss amount paid to date

(9) The complete summary of all the facts on which the reasonable belief of the insurance fraud is based, that has been prepared pursuant subdivision (a)(5) of Section 2698.36.

(A) The summary shall include the following information, if known:

1. The facts that caused the reporting party to believe insurance fraud occurred or may have occurred.

2. The suspected misrepresentations and who it was that allegedly made them.

3. How the alleged misrepresentations are material and how they affect the claim or insurance transaction.

4. Identification of pertinent witnesses to the alleged misrepresentation.

5. What documentation there is of the alleged misrepresentation.

(B) In addition, the summary prepared pursuant to this subdivision (d)(9) shall include a statement as to whether or not the investigation is complete.

(10) Disaster claim indicator

(e) Other agency referral information, as appropriate

(1) Names of other authorized governmental agencies receiving this referral

(2) Names of any District Attorney's Office receiving this referral

(3) National Insurance Crime Bureau (NICB) referral indicator

(4) The names of any other agencies receiving this referral

(f) Referral contact information, as appropriate

(1) Referral contact name, title, and phone number

(2) Claim or case file handler and phone number

(3) Name and phone number of person who completed referral

(4) Date referral was completed (not required if submitted electronically)

(g) Information for each party associated with the referral

(1) Name of party and identification of the role of the party to the loss

(2) Phone number

(3) Address, city, state, and zip code

(4) Date of birth or age

(5) Social security number

(6) Tax identification number

(7) Driver's license number

(8) State of party's driver's license

(9) Vehicle license plate number

(10) Vehicle license plate state

(11) Vehicle identification number

(12) Other names or identifiers used by the party

(13) Claim of injury indicator

(10 CCR§§ 2698.37 &2698.38)

68. Of particular significance to this discussion are the DOI requirements for fraud training not only for SIU personnel but also claims department personnel.

a) The insurer shall establish and maintain an ongoing anti-fraud training program, planned and conducted to develop and improve the anti-fraud awareness skills of the integral anti-fraud personnel.

(b) The insurer shall designate an SIU staff person to be responsible for coordinating the ongoing anti-fraud training program.

(c) The anti-fraud training program shall consist of three (3) levels:

(1) All newly-hired employees shall receive an anti-fraud orientation within ninety (90) days of commencing assigned duties. The orientation shall provide information regarding:

(A) the function and purpose of the SIU;

(B) an overview of fraud detection and referral of suspected insurance fraud to the SIU for investigation;

(C) a review of the Fraud Division's insurance fraud reporting requirements;

(D) an organization chart depicting the insurer's SIU; and

(E) SIU contact telephone numbers and email addresses.

(2) Integral anti-fraud personnel shall receive annual anti-fraud in-service training, which shall include:

(A) review of the function and purpose of the SIU;

(B) introduction/review of the written procedures established by the SIU regarding the identification, documentation, and referral of incidents of suspected fraud to the SIU;

(C) identification and recognition of red flags or red flag events;

(D) any changes to current procedures for identifying, documenting, and referring incidents of suspected insurance fraud to the SIU;

(E) the Fraud Division's insurance fraud reporting requirements; and

(F) introduction/review of existing and new, emerging insurance fraud trends.

(3) The SIU personnel shall receive at least five (5) hours of continuing anti-fraud training per calendar year. The training shall include instruction in one or more of the following topics:

(A) investigative techniques;

(B) communication with the Fraud Division and authorized governmental agencies;

(C) fraud indicators;

(D) emerging fraud trends; or

(E) legal and related issues.

(d) The training requirements stated in subdivision (c) of this Section 2698.39 shall not apply to persons retained to provide an expert opinion on a medical, technical, or scientific topic on behalf of the insurer and who do not participate in the claims handling or decision making function of the insurer.

(e) Training, instruction, or courses that may be used in order to satisfy the requirement stated in subdivision (c)(3)

> of this section shall include, without limitation: anti-fraud conferences; SIU roundtables hosted by the Fraud Division; anti-fraud association meetings and trainings; and insurer in-house trainings.
>
> (f) Records of the anti-fraud training shall be prepared at the time training is provided and be maintained and available for inspection by the Department on request. The training records shall include:
>
> (1) the title and date of the anti-fraud training, instruction, or course;
>
> (2) the name, title, and contact information of the instructor(s), to the extent applicable;
>
> (3) copies of the training, instruction, or course materials or, if the materials are unavailable, a description of the training, instruction, or course content;
>
> (4) the length of the training, instruction, or course; and
>
> (5) the name and job title(s) of participating personnel.
>
> (10 CCR§2698.39).

69. It is assumed for the purposes of this Supplemental Report that Chubb claims department employees, including, but not limited to, those claims personnel involved in the handling, adjusting and supervision of the Pollock claim, have received the State of California required anti-fraud training. This training includes, among other topics, "fraud detection and referral of suspected insurance fraud to the SIU for investigation," and "a review of the Fraud Division's insurance fraud reporting requirements." Given this training, if not the actual experience and knowledge obtained from claims handling, it would be expected that those who handled, adjusted or supervised Chubb's handling of Pollock's claims would be capable of identifying suspected insurance fraud and reporting that fraud to Chubb's SIU or other appropriate government agencies. Despite this training, along with the likely experience and knowledge, there is no

evidence that Chubb claims department employees at any time during their handling of Pollock's claim identified and reported the types of insurance fraud that Chubb only now alleges that the Pollock's engaged in in the presentation and documentation of their claim. Indeed, Chubb assigned the Pollock claim to its SIU unit much earlier in its investigation, but for reasons other than those it now contends establish that Pollock has committed insurance fraud. (See Miller Report, pp. 98-103). Despite the fact that Chubb's trained SIU representatives were involved previously in the claim, they did not identify any of the facts or conditions that now underpin Chubb's current fraud allegations.

70. According to the Court's April 1, 2025, Order Granting Motion for Leave to File an Amended Pleading ("Order"), "Federals' new defenses and counterclaim are based on the following representations by Plaintiffs it contends were false at the time they were made:

> 1) a statement on October 26, 2020, by Mr. Pollock to Federal "that because of the scale and scope of [their] property, [the] restoration and/or reconstruction process will likely take between 1 and 3 years[,] [Citation omitted] 2) two proofs of loss submitted under penalty of perjury in August 2021 claiming that the cost to demolish and rebuild would exceed $85 million and that Plaintiff's living expenses during the rebuilding period would exceed $15 million [citation omitted]; and 3) statements in a September 27, 2021 letter from Plaintiff's counsel to Federal that identified the "purported basis for their $100.3 million "replacement value" insurance claim; testing and conclusion purportedly provided by an industrial hygienist at Kaisen Safety Solutions, Dawn Bolstad-Johnson.
>
> (Order, p. 4).

71. It is significant that the foregoing alleged fraudulent statements were

made during Chubb's handling, adjustment and supervision of Pollock's claim and yet at no time did Chubb's claims handlers contend that these statements, or any others made during that same period, were suspicious fraudulent statements that warranted referral to Chubb's SIU and to the appropriate agency. Indeed, "[a]n insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud **during the handling of insurance transactions** and referring it to the SIU as part of their regular duties." (emphasis added).

72. Further, and even though Chubb's SIU was involved in other issues with the Pollock claim, at no time did Chubb's own SIU report that any of the foregoing conduct was considered suspected insurance fraud. Indeed, as with the other issues addressed by Chubb's SIU, at no time did Chubb's SIU refer any of the foregoing suspected fraudulent conduct to the appropriate agency for further action as it would be required to do if there was suspected insurance fraud. (See Miller Report, pp. 98-103).

73. In addition to the foregoing, Federal also alleges that prior to the fire the Pollock's "spent in excess of $400,000 addressing flawed construction and necessary reports," and although they attempted to sell their home between 2011 and 2020, but were unable to do so. (Order, p. 5). Federal further alleges that only "small amounts of soot, ash, and char entered the Property," and that the Pollock's had done "nothing to clean or remediate their Property." (Id. at p. 6). Federal also alleges that the home was damaged not by fire but rather by pre-existing wear and tear, gradual release or deferred maintenance. (Id.).

74. Again, there is no evidence that any of these additional allegations

were viewed by Chubb's claims personnel, including its SIU personnel, during the claims handling process as indicators of suspected fraud. Chubb clearly had the opportunity early in its handling of Pollock's claim to identify any of the foregoing alleged fraud. Nonetheless, Chubb did not do so even though Chubb's claims handling and SIU personnel were highly trained in the identification and reporting of insurance fraud as required by State law and regulation. Indeed, claims handlers are also trained to take into account wear and tear in building and personal property when adjusting a claim. (See Property Insurance Practices, Popow, Donna J. ed. (The Institutes,1st ed. 2011) §1.39). [16] Chubb's failure to timely identify these alleged acts of fraud, in compliance with insurance industry claims handling standards and state law and regulation, casts serious doubt on the veracity of Chubb's fraud allegations.

75. Insurers commonly use "red flags" to identify potential fraud. The following is noted in one insurance industry text regarding "red flags:"

> The existence of such fraud indicators does not, by itself, establish that a claim is fraudulent. It may raise a suspicion of fraud but it cannot be emphasized enough that mere suspicion is not a basis to deny a claim. What the presence of one or more red flags does mean is that the claim should be investigated further.
>
> ("Claim Fraud Fundamentals," American Educational Institute, p. 51)
>
> Thus, an investigation for fraud should be undertaken only when the insurer can point to specific facts that justify such action. These facts are known as "fraud indicators" or "red flags." Every kind of claim has its own set of

[16] Likewise, Chubb inspected Pollock's property several times between 2001 and 2011 and never reported any problems with the home including wear and tear. (See Bates Nos. Chubb_15510-11856).

> insurance fraud indicators or red flags. According to a former Chief Investigator for the California Department of Insurance, Fraud Bureau, red flags can be defined as "elements of insurance claims which are known throughout the industry to be common to fraudulent claims.
>
> (Id. at p. 75).

76. Despite the widespread use of "red flags' to identify potential fraud, none of the red flags identified during the review of the Pollock claim by Chubb's SIU unit were found to support a claim of fraud. This is particularly important here because as noted *supra*, Chubb has alleged that the Pollocks were seeking to sell their home before the fire and suggested that the Pollocks were under financial pressure because of the cost of their home. One widely recognized "red flag" is that an insured's home was up for sale and/or the insured had financial difficulties before the loss. (Property Investigation Checklists, Zalma, Barry (Thomson Reuters 13th ed., 2021) §1:11, p. 15). It is assumed for the purposes of this report that the Chubb claims handlers, supervisors and managers involved in the handling of Pollock's claim were aware of this and other "red flags" during their handling of Pollock's claim. In other words, they were trained to spot "red flags," and they knew how to investigate and evaluate them (which included a review of tax returns, bank statements, and other financial documents) to ascertain whether the claim was fraudulent. This further underscores the conclusion herein that Chubb failed to find any fraud during its handling of Pollock's claim, despite referral of the Pollock claim to its SIU division and collecting substantial financial documents, conducting four days of EUOs, running background checks and otherwise leaving open the fraud investigation

for approximately two years, eleven months of which was ***after*** all of the statements now alleged by Chubb to be fraudulent.

77. It is particularly critical to identify possible insurance fraud early in the claim handling in order to be able to thoroughly investigate the possible fraud. In one insurance industry text the following was noted:

> The investigation of a suspicious claim usually involves taking statements from various person, including the insured. This should be done as soon as possible after a loss occurs, and the statements should be recorded if possible. Keep in mind that if a claim is denied and the insured sues, the trial is likely to occur many months or even years after the initial stages of the investigation. A recorded statement is likely to be far more valuable than your notes on a conversation with a witness…The insured's statement should be taken, and preferably recorded, as soon as possible after a loss occurs. ("Claim Fraud Fundamentals," American Educational Institute, p. 51).

78. Likewise, [a]lthough a thorough investigation should include independent sources, the insured remains the insurer's primary source of information regarding a claim. ("Claim Fraud Fundamentals," American Educational Institute, p. 23).

79. This is particularly important because "[l]eads that tend to support payment of the claim must be investigated as thoroughly as those that may support a fraud or arson defense, and evidence that tends to show that the insured is innocent of any wrongdoing (i.e., "exculpatory" evidence) cannot be ignored" (Claim Fraud Fundamentals [Am. Ed. Inst., Inc., 2006], pp. 55–56). It does not appear from the record that Chubb sought to ascertain the existence of any exculpatory evidence, either before or after commencement of litigation, or

really discussed any of its concerns regarding the supposedly "fraudulent" statements with the Pollocks to obtain clarity and understanding.

80. Further, a disagreement over the amount of the loss (or the remedy therefor) is not a reason to refer the claim to SIU. As one insurance industry author has pointed out: "slight or trivial exaggerations, innocent or inadvertent mistakes in computation, or statements of opinions, made in good faith, regarding the property's value, do not provide the requisite intent to void the policy" (Popow, §4.34). Similarly, "Courts have held repeatedly that an honest mistake or mere over-estimate by an insured will not support a defense of fraud, misrepresentation, or concealment in the claims process." ("Claim Fraud Fundamentals," American Educational Institute, p. 20). Despite these recognized standards, there is no evidence that Chubb ever evaluated whether any of Pollock's supposedly "fraudulent" statements were asserted as matters of opinion and not fact. It was critical to timely make this determination in order to avoid any subsequent allegations of fraud which could not be supported. Indeed, according to the FC&S, it is "especially true" that, when an insurer "does not have overwhelming proof of a fraudulent statement or fraudulent conduct," it will not apply the concealment provision (FC&S, "Concealment or Fraud," p. 2).

81. Overall, Chubb's qualified and trained claims handlers never found any basis to allege insurance fraud against Pollock during the claim handling process despite the well-recognized standards for the investigation of fraud claims. Now, Pollock faces allegations of fraud years after the reported claim, which are not based on the claims handling, where that fraud would and should have been discovered. In closing the SIU case regarding the Pollocks without

any assertion of fraud or wrongdoing on the part of the Pollocks, it could only be concluded that Chubb's claims handlers did not find the fraud that Chubb now alleges Pollock committed. Since those well-trained claims handlers were at the Property many times following the fire, working with many of Chubb's and Pollock's retained consultants and experts, it must also be concluded that they would have been in best position to identify fraud if in fact it was there.

C. CHUBB HAS FAILED TO NOTIFY POLLOCK'S MORTAGE COMPANIES FURTHER DEMONSTRATING CHUBB'S CONTINUING EFFORTS TO AVOID PAYMENT OF POLLOCK'S CLAIM.

82. Chubb has contended in its counterclaim that it does not owe Pollock any further payments, that the Pollock claim is barred and that Chubb is entitled to recovery of the amounts it has already paid to Pollock. See Miller Report, pp. 61-63).

83. Chubb contends in its counterclaim the following:

> Plaintiffs' claim is barred, in whole or in part, by Plaintiffs' intentional misrepresentation and concealment of material facts. Plaintiffs' conduct detailed in the First Counterclaim for Breach of Contract below is a material breach of the Policy's concealment or fraud provision, which states that "[w]e do not provide coverage if you or any covered person has intentionally concealed or misrepresented any material fact relating to this policy before or after the loss." As detailed in the Counterclaim, Federal has been substantially prejudiced by Plaintiffs' misrepresentation and concealment.

84. Further, Chubb alleges that "Plaintiffs' misrepresentations and omissions constitute a material breach of the Policy's "concealment or fraud" provision because "Plaintiffs intentionally concealed and misrepresented material facts

relating to their insurance claim."

85. According to Chubb, "Plaintiffs' breach of the concealment or fraud provision voids the Policy." (FEDERAL INSURANCE COMPANY'S ANSWER TO FIRST AMENDED AND SUPPLEMENTAL COMPLAINT AND COUNTERCLAIMS,1 Filed 02/24/25 Page 32 of 34 (Emphasis in Original))

86. Federal also alleges that it "is entitled to restitution of the amounts it paid Plaintiffs under the Policy, which is now void, including without limitation the amounts that Federal paid Plaintiffs for additional living expenses between Plaintiffs' August 2021 proofs of loss and Federal's March 2024 coverage-position determination."

87. Federal further alleges that it "is also entitled to recover (i) the costs that it incurred after August 2021 attempting to replicate and verify the testing conducted by Kaizen Safety Solutions; and (ii) the costs that it incurred investigating and adjusting Plaintiffs' August and September 2021 claims that the Property could not be repaired and needed to be completely replaced."

88. This requires an analysis, pursuant to insurance industry standards, of the mortgagee clause in the Policy.

89. The Policy provides:

> **Mortgagee or loss payee**
>
> b. If we deny your [insured's] claim, that denial shall not apply to a valid claim of the mortgagee or loss payee, provided that the mortgagee or loss payee:
>
> (1) notifies us of any change in ownership, occupancy or substantial change in risk of which the mortgagee is aware;

> (2) pays any premium due under this policy on demand , if you have neglected to pay the premium, and
>
> (3) 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 appraisals and legal action against us, apply to the mortgagee and loss payee.
>
> (Policy, Special Conditions Page Y-6).

90. It has long been recognized in the insurance industry that "a mortgagee is entitled to make a claim even if the insured's claim can be denied." (Property Claim Practices, Popow, Donna J. ed., (The Institutes, 1st ed., 2011) §1.12). The purpose of the mortgagee clause is to protect the mortgagee's interest in the property. The Policy was endorsed with the Bank of America and Citibank, N.A. as mortgagees. It is understood in the insurance industry the mortgagee clause creates a separate contract between the insurer (State Farm) and the mortgagee (Bank of America).[17]

91. For example, in one insurance industry text directed to claims handlers, it is noted that,

> When the claim representative finds evidence indicating that the insurer is liable to the mortgagee but not to the insured, he or she **must promptly inform the insurer**, who may elect to pay the mortgagee the amount of the damage to the property or the limit of liability under the policy and have executed articles of subrogation and assignment (citation omitted), or it may elect to pay the mortgagee the full amount of the mortgage debt and take an assignment of the mortgage.

(Thomas & Reed, p. 63; emphasis added)

92. An example of the insurance industry's recognition of the importance of the Mortgagee Clause is found in State Farm's extensive standards for the investigation and handling of mortgage claims. Pursuant to these standards, once State Farm (the largest personal lines insurer in America) has denied the claim to the insured, "a written separate notice that we [State Farm] have denied the claim to the insured **should be given to the mortgagee** in order that the mortgagee may present a claim to the extent of the mortgagee's interest" (State Farm Operation Guide 70-152, "Mortgage Assignments," p. 2, attached hereto as Exhibit J; emphasis added). These standards set forth the requirements for investigating and evaluating the claim, and then paying the mortgagee.

93. Elsewhere, State Farm has instructed its claims handlers that "[t]he mortgage clause in insurance property forms grants specific rights and status to mortgagees, including the payment of loss to the insured and mortgagee, as their interests appear" (State Farm Operations Guide 75-100, "Claim Interpretations – First Party," p. 14; hereinafter, "OG 75-100"). State Farm's guidelines provide detailed instruction on how the mortgagee claim is to be investigated, including inspection of the property and the preparation of an estimate (Id.). None of these requirements, which are also insurance industry standards, were followed by Chubb.

94. Here, Chubb has denied Pollock's claim and, therefore, is obligated under the express terms of the Policy, and pursuant to insurance industry

claims handling standards, to advise the Mortgagees of that denial so that they can present their own claims. Chubb has not done this, thereby preventing the mortgagees from being able to perfect their rights under their contract with Chubb. This action only inures to Chubb's benefit. By ignoring the mortgagees' rights under the Policy Chubb does not have to pay the mortgagees to the extent of their interest in the Property.

95. This is particularly important here because Chubb's allegations of fraud, misrepresentation and concealment would not apply to the mortgagees since they have a separate contract with Chubb and were in no way involved in the alleged fraud, misrepresentations and concealment. Chubb, therefore, would not be able to deny the mortgagees' claims for this reason. As noted by one insurance industry source:

> The Standard Fire Policy permits the insertion of a Standard Mortgage Clause, which provides that in the event of a covered loss, the policy proceeds are payable to a named mortgagee as its interest may appear. The Standard Mortgage Clause, which applies only to buildings and not to personal property, creates a separate contract between the insurer and the mortgagee. Under this type of clause, the mortgagee has an independent right to recover under the policy, and its rights are not affected by the conduct of the insured. That is, fraud or arson by the insured will not bar a recovery under the policy by a mortgagee, provided the mortgagee itself is innocent of any involvement in the fraud or arson.
>
> ("Claim Fraud Fundamentals," American Educational Institute, p. 38).

96 As a result Chubb could have an obligation to pay the mortgagees substantial amounts above what it has paid to Pollock to date for the damage to the Property. By failing to advise the mortgagees' of Chubb's denial Chubb

further its efforts to not pay Pollock's claim. This is particularly egregious here given that the mortgagees would have a valid claim that Chubb could not deny because of fraud. Chubb's failure to acknowledge this claim further demonstrates that Chubb's goal with regard to Pollock's claim is to pay as little as possible (regardless of coverage) even if the amount paid is less than would should have been paid.

98. Chubb's continuing effort to avoid payment of a valid claim call attention to the fact that over the past few years there has been an increasing effort by insurers to allege insurance fraud months if not years after the insured has reported the claim even though the alleged fraud was not discovered (assuming it existed) early in the insurer's claims handling process. (See Jenee Child vs. Certain Underwriters at Lloyd's, London, Sup. Ct., CA, San Bernardino Cty., Case No.: CIVSB2300838; Royal Crest Dairy, Inc. v. Continental western Insurance Company, USDC, Dist CO., Civ Action No: 1:17-cv-00949-RM_kLM, and Canyon Club Condominium Owners Association vs. American Family Mutual Insurance Company, USDC, Dist. CO., Case No.: 18-CV-00683-DDD-STV). The allegations in these cases are surprisingly similar to those made in this matter in that it is alleged, as here, in that the damage was caused by wear and tear and not a covered cause of loss and that the insured submitted proofs of loss with excessive claim amounts.

99. This trend is certainly consistent with Chubb's effort to avoid payment of Pollock's claim. As with Chubb's close association with other insurers who have claims payment reduction and delay programs, Chubb again associates

itself with other insurers in the effort to delay or deny payment of claims based on fraud allegations brought long after the claim was first reported. The similarity of these associations cannot be ignored as they too provide a further understanding of Chubb's efforts to delay and deny claim payments that were otherwise owed.

V. CONCLUSION

100. I understand that there may be additional discovery yet to be completed in this case, including depositions of Federal personnel. The opinions expressed herein are subject to change or modification, depending on the results of any future investigation and discovery in this case.

19th day of August 2025