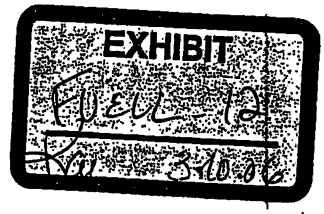
LIABILITY BEST PRACTICES – PRODUCT MANAGEMENT

THE FOLLOWING BEST PRACTICES ARE FOR INTERNAL MANAGEMENT PURPOSES ONLY. THEY ARE INTENDED TO PROMOTE THE EFFECTIVE AND EXPEDITIOUS MANAGEMENT OF LIABILITY CLAIMS AND DO NOT NECESSARILY REFLECT THE LEGAL REQUIREMENTS OF ANY PARTICULAR JURISDITION.



COVERAGE

Weighted Value: 0.15

Policy Confirmed

Pertinent policy is confirmed within 1 business day of receipt of claim by case manager. Coverage source is verified through CIID, Cesar or other system designed for this purpose and documented in Z-Notes or other file documents. If systems do not contain required information, then the file documents contact with the underwriter, IRDN or other source to confirm issuance and key parameters of policy. Type of policy, applicable limits and other key policy parameters are documented in file.

Timely Recognition and Resolution of Coverage Issues

All applicable coverage issues are recognized immediately upon receipt of information (first notice, pleading, letter, investigation report, etc.) evidencing the potential coverage issues. All coverage issues are proactively resolved in a timely manner.

Excess and aggregate impairment issues are promptly recognized and handled appropriately. Where appropriate, excess carriers are promptly notified of the potential estimated exposure.

Coverage Investigation

Investigation of facts relevant to coverage issues initiated no more than 2 business days after receipt of information evidencing said issue. Investigation is pursued in a proactive manner until all necessary information is obtained. File documentation must reflect all coverage investigation efforts.

Timely Coverage Determination and Letter

An effective coverage analysis and determination will be made as soon as practicable, but no more than 30 days from our receipt of all necessary coverage-related information. In the event we identify a coverage issue(s), we will issue a detailed reservation of rights or declination letter (as appropriate) to our insured as soon as practicable, but no more than 30 days from our receipt of information evidencing said issue(s).

The extent of available coverage will be re-evaluated within 30 days of our receipt of any new, material information.

Quality Coverage Letter

All coverage letters will be written in a clear, concise and understandable manner, with all-pertinent facts and relevant policy provisions being recited and effectively explained. Our reservation of rights letters will clearly explain the bases for our reservations (pertinent facts and relevant policy provisions) and the information needed to allow us to resolve the coverage issue(s). Declination letters will clearly explain the bases for our denial of coverage (pertinent facts and relevant policy provisions), and shall also advise the insured that we will re-evaluate our coverage position upon presentation of additional, material information relative to the relevant coverage issue(s).

State Regulatory Requirements

Some states have regulations concerning the content and timing of coverage letters. Case managers must be familiar with the applicable regulations in their jurisdictions and see that all letters are in compliance with such regulations.

Deductible/SIR

The file indicates the amount of any applicable deductible or SIR. The file demonstrates that the SIR has been appropriately exhausted prior to our payment under the policy.

CUSTOMER SERVICE

Weighted Value: 0.10

Access Set-Up

Claim file is completely registered in ACCESS within 1 business day of receipt of the claim by Zurich.

Prompt, Meaningful Contact

The insured and claimant are to be contacted within 1 business day from receipt of the claim by Zurich. The case manager must be the one to make contact with those parties. Contact by third parties, such as independent adjusters, does not qualify as contact.

Contact is defined as timely communication with the appropriate parties and the securing of any available information necessary to adjust the claim. Leaving voice mail messages does not qualify as a reasonably strong effort at making contact.

If there is representation of the claimant by counsel at the outset (including situations where the lawsuit is our first notice), initial contact with the attorney should be made over the telephone, within 1 business day, to obtain all available information concerning claimant's allegations relative to liability, injuries and damages.

On transferred files, the case manager will send a letter to all interested parties introducing himself/herself within 5 business days of the transfer.

Special Handling Compliance

The claim file reflects that the case manager has recognized and complied with all applicable special handling instructions (e.g. timely notification, consultation, site coding, etc.).

Communication

The case manager shall communicate with the insured on a regular basis (at least every 90 days) throughout the life of the claim to ensure that the insured is appropriately apprised of the status and resolution strategy of the claim.

INVESTIGATION

Weighted Value: 0.15

Investigation Strategy

The case manager is responsible for conducting an investigation into all aspects of the claim (liability, injuries, damages, contribution/subrogation, etc.). The case manager should develop and pursue a focused and proactive strategy to obtain all necessary evidence and information, and should not abandon the investigation to counsel or the discovery process. The strategy should routinely be reviewed and updated to respond to changed facts and circumstances.

Timeliness of Investigation

An appropriate investigation is initiated immediately upon receipt of the claim file by the adjuster or receipt of new information that may materially impact the claim exposure.

Independent Evaluation

Liability, injuries and damages are independently evaluated by the case manager. The case manager's rationale is documented in the file, which properly addresses the pertinent facts, evidence, defenses, other responsible parties, and any other relevant factors and considerations affecting the case exposure.

Timeliness of Evaluation

The case manager evaluates the claim exposure upon receipt of new information that potentially impacts his/her assessment of liability, injuries or damages. An evaluation is completed and documented in the file within no more than 30 days of receipt of said information.

Injury and Damage Verification

All claimed injuries and damages are evaluated and verified by the case manager through credible evidence and/or the use of appropriate experts/vendors. File documentation will support the degree of injuries and damages outlined in the case exposure evaluation.

Recognition of Potential Fraud

Potential fraud indicators are promptly recognized and referred to the Zurich SIU department for investigation within no more than 30 days of recognition.

RESERVING

Weighted Value: 0.15

Initial Reserve

Initial reserves are set within 1 business day of receipt of the claim by the case manager. The initial reserve will be based on the limited information received from the notice of loss.

Exposure Recognition and Reserving

Estimated realistic case exposure is proactively recognized as soon as practicable, but no more than 30 days from our receipt of information evidencing that exposure (or change in exposure). Appropriate case reserves are set within said 30-day period. Case reserves reflect our estimated realistic exposure given the degree of liability, severity of loss and measure of damages. Reserves are established in accordance with policy limits, terms and conditions.

Expense reserves reflect all sums expected to be incurred in the defense, investigation and adjustment of the claim. For litigated cases, expense reserves must be supported by a litigation plan and budget (with the exception of Level One cases).

Reserve adequacy is routinely re-evaluated at least every 180 days.

File Supports Reserve

The claim file contains a clear explanation for all reserves, as well as all information needed to properly support said reserves (i.e. case summary, counsel's evaluation letter, jury verdict research, etc.). The claim file must stand on it's own in this regard.

As respects MCU level files, the case manager shall prepare an effective case summary report clearly explaining the bases for the recommended reserve. That report will contain all material facts and information effecting claim exposure, a thorough evaluation of the estimated realistic claim exposure (using, as may be appropriate, decision tree analysis, jury verdict research, defense counsel's assessment, etc.), and a customized resolution strategy and action plan.

Authority

The reserve is posted within the case manager's authority. If the necessary authority is extended by the case manager's supervisor, claim manager or senior management, the extension of that authority must be properly documented in the file.

LITIGATION MANAGEMENT

Weighted Value: 0.15

Retention of Defense Counsel

The case manager will refer a new suit to qualified defense counsel within 1 business day of receipt of the suit. Unless prohibited by applicable law or the Special Handling Instructions, suits will be referred to Staff Legal or ZAAP counsel, where available.

If the suit is referred to a firm other than Staff Legal or ZAAP counsel, the rationale for that assignment must be clearly documented in the file. If the suit is referred to counsel other than Staff Legal or ZAAP counsel, the case manager must secure and confirm in writing counsel's agreement to comply with Zurich's Litigation Management Guidelines for Defense Counsel (Guidelines) and billing expectations. The case manager must also negotiate reasonable billing rates, considering the jurisdiction, nature of the case and degree of expertise required.

Litigation Plan and Budget

The case manager is to confer with defense counsel to develop a focused, cost-effective litigation strategy, regardless of the complexity of the case. Level One cases are an exception. Said litigation strategy should be completed and documented in the file within 45 days of referral to counsel.

The plan should include an initial analysis of the suit, development of defense objectives and strategy, identification of required activities, target dates for completion of those activities and a detailed budget projecting the costs associated with said activities. The litigation plan should target the immediate actions necessary to move the case closer to a reasonable disposition and should not merely be a generalized outline of the anticipated progress of the litigation from start to finish.

The litigation plan should be routinely re-evaluated (at least every 180 days) to reflect material changes in facts, law, or other relevant factors.

Management of Counsel

To the extent permitted by law, the case manager will proactively manage the litigation process consistent with the agreed litigation plan, budget, and Zurich's Guidelines. Where the Guidelines require defense counsel to consult with the claim handler before engaging in certain defense activities (consistent with applicable law), the file will clearly document that said consultation has occurred.

Review and Payment of Legal Bills

The case manager is responsible for the review and payment of all legal bills. The claim file shall reflect that the case manager and/or Litigation Management has reviewed all legal bills prior to payment. Legal bills shall be reviewed and processed within 30 days of receipt, unless a valid reason is documented in the file. The case manager shall challenge all discrepancies in billing rates, as well as any deviations from the litigation plan, budget and/or the Guidelines, and will resolve those issues promptly.

VENDOR SELECTION AND MANAGEMENT

Weighted Value: 0.10

Vendor Selection

Where necessary, the case manager will select and retain qualified vendors to assist in the investigation, evaluation and/or adjustment of the claim. The rationale supporting the necessity and selection of a vendor should be clearly documented in the file.

Vendor Management

The retention of any vendor must be memorialized in a vendor assignment/retention letter, which specifies the scope of the assignment, the time frame for performance and the agreed budget. The case manager is to proactively manage the vendor to ensure the timely completion of the assignment and the effective control of the associated costs.

Review and Payment of Vendor Bills

The case manager is responsible for the review and payment of all vendor bills within 30 days of the receipt of the bill, unless a valid reason for the delay is documented in the file. As permitted by applicable law, the case manager shall challenge any inappropriate and unreasonable charges, as well as any deviations from the scope, budget, etc., and shall resolve any such issues promptly.

RESOLUTION

Weighted Value: 0.15

Disposition Plan

The case manager will develop and document a customized strategy for the resolution of the claim within 45 days of receipt of the claim. The case manager's plan must consider what critical information is necessary to facilitate an early resolution of the claim. The disposition plan should be reviewed routinely (at least every 180 days) to ensure that it comports with the facts, law and circumstances of the claim.

With respect to claims in litigation, the litigation plan shall serve as the claim disposition plan.

Negotiations

Prior to commencing negotiations, the case manager must develop a settlement strategy. That strategy will outline the settlement value and plan of action. The case manager should consider the use of creative approaches to facilitate the resolution of claims, including structured settlements.

Negotiations are to be conducted by the case manager. Level One cases are an exception. If negotiations are not conducted by the case manager, then the file must document the rationale for allowing defense counsel or other parties to conduct the negotiations.

File Supports Payment

Claim file is resolved within the reasonable settlement value. Circumstances of claim must support the decision to settle and the reasonable settlement amount. Settlement value supported by appropriate file documentation.

Settlement Authority

Claim file reflects that settlement was made within authority granted to case manager. If authority is extended by case manager's supervisor, claim manager or senior management, then file should clearly reflect the extension of authority by such person.

Subrogation/Contribution

Potential subrogation and contribution opportunities are identified and pursued in a timely manner. The case manager's strategy to obtain the desired recovery and/or contribution is documented in the file.

Potential subrogation opportunities are promptly identified and referred to the Recovery Unit within no more than 30 days of identification. Salvage is identified and properly disposed of to minimize storage expenses and to maximize recovery. The claim file will clearly document all subrogation, contribution and salvage activities.

FILE MANAGEMENT

Weighted Value: 0.05

Proper Underwriting Company

All claim correspondence will reflect the appropriate underwriting company name applicable to the specific policy at issue.

Diary

The effective maintenance and use of a diary system is absolutely critical to our ability to proactively manage and adjust the claim. As such, every file should evidence the use of an effective diary management system by the case manager. As such, every file should evidence meaningful activity by the case manager at least every 90 days. Deviations from that schedule shall be permitted given the particular circumstances of a claim, if such circumstances are properly documented in the claim file.

Reinsurance

The case manager will respond to all reinsurance inquiries within ten (10) business days of receipt of the inquiry.

Data Quality

The case manager is responsible for the quality of all claim-related coding on the file. In particular, the case manager is responsible for ensuring that correct codes are used for accident description codes, agent of loss codes, Val ID's, severity codes, customer site codes and pay kind codes. The case manager is also responsible for completing all ACCESS registration screens as the pertinent information becomes available.