



CALIFORNIA DEPARTMENT
OF INSURANCE

2011 ANNUAL REPORT
of the INSURANCE COMMISSIONER

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August 1, 2012

The Honorable Edmund G. Brown, Jr.
Governor
State of California
State Capitol, Suite 1173
Sacramento, CA 95814

Dear Governor Brown:

I am pleased to provide to you the *2011 Annual Report of the Insurance Commissioner* as required by California Insurance Code ("CIC") section 12922. The Report describes in detail the work of the California Department of Insurance (CDI) during the 2011 calendar year. The Department's core function, as the regulator of the state's insurance industry with \$125 billion in annual revenues, is vital to the health and well-being of Californians and California's economy. In order to carry out this important role, we have improved upon department processes, while also introducing new initiatives that are necessary to protect consumers in today's insurance marketplace. My administration has made considerable progress on an ambitious consumer and business protection agenda. As of publication, following are highlights of what we have accomplished since taking office on January 3, 2011:

Health Care Reform

Issued emergency regulations on my first day as Insurance Commissioner that require health insurers to put more of the premiums they collect into medical care instead of health insurance company profits and overhead, one of the most important pieces of federal health care reform.

- Issued regulations prohibiting health insurers from denying health insurance to children with pre-existing conditions.
- Implemented new benefits for consumers under the Affordable Care Act, including the elimination of lifetime caps in health insurance coverage, elimination of co-payments for preventive services, elimination of co-insurance for women's preventive health services, and requirements that all health insurers provide maternity benefits and that they allow parents to keep their children on their health insurance up to age 26, among others.
- Provided technical assistance, staff resources and other assistance to the California Health Benefit Exchange to assist in the establishment of the Health Benefit Exchange.
- Worked to implement additional elements of the federal Affordable Care Act with the federal Department of Health and Human Services, the California Health and Human Services Agency, and the California Health Benefit Exchange.
- Required health insurers to provide treatment for autism, including behavioral treatment.

Premium Savings

- Reviewed health insurance rate increases in the individual and small group markets and obtained reductions in proposed rates, resulting in \$152 million annually in premium savings to individuals and small businesses.

-
- Processed over 1,500 property-casualty rate filings under Proposition 103 in our first 18 months. During this time, the Department reduced the overall amount of requested rate increases by \$69 million and approved over \$482 million in rate reductions, totaling over \$551 million in savings to California consumers and businesses. This total includes approximately \$132 million in rate reductions for personal auto coverage.
 - Lowered medical malpractice insurance rates, saving doctors, dentists and other medical providers \$44 million in premiums annually.
 - Assisted financially distressed homeowners by directing insurers who sell "forced placed homeowners insurance" to reduce their rates.
 - Approved changes to residential California Earthquake Authority (CEA) earthquake insurance policies to make them more affordable, including an average rate reduction of 12 percent and requiring insurers to provide personal property coverage.

Insurance Fraud

- Combated fraud, resulting in over 1,100 arrests and over 859 convictions for crimes that included auto insurance fraud, fiduciary theft, embezzlement, identity theft, workers' compensation fraud and other criminal activity in the underground economy.
- Led a national investigation of life insurance companies for failing to pay death payments to beneficiaries when due. This investigation and related enforcement actions have resulted in two settlement agreements with major national life insurance companies to reform their business practices and to disgorge over \$500 million in unpaid life insurance benefits and tens of millions of dollars in penalty equivalents.
- Filed major anti-fraud lawsuits to combat hundreds of millions of dollars in medical provider fraud.
- Participated in the Brown Administration's Underground Economy Joint Task Force to investigate and prosecute employers who fail to comply with wage and hour, labor safety and workers' compensation insurance requirements.

Regulations and Legislation

- Sponsored Assembly Bill 52 to provide the legal authority to reject excessive health insurance and HMO rate increases.
- Sponsored 9 strong consumer protection bills that were signed into law during the 2011 legislative session. These include bills that will protect seniors from fraudulent activities while purchasing annuities, ensure that agents and brokers do not engage in predatory practices in the selling of reverse mortgages, give life insurance beneficiaries the option to receive payments via a retained asset account, and require disclosure in workers' compensation policies in order to save businesses from spending on unexpected costs.
- Issued regulations to protect homeowners by requiring insurers and insurance agents and brokers to provide consistent, complete and comprehensive estimates of home replacement costs, so that homeowners are armed with accurate information with regard to the amount of insurance coverage needed to replace their home if destroyed. We also defended these consumer protection regulations from litigation brought by home insurers.
- Issued regulations to prevent health insurers from arbitrary rescissions of health insurance policies and defended the same from litigation brought by the health insurance industry.
- Initiated rulemaking process on consumer issues associated with collision repair centers.

Consumer Protections

- Reformed the Workers Compensation "Pure Premium Benchmark" process and provided workers' compensation market stakeholders with expert actuarial reviews of workers' compensation cost structure changes.

-
- Surveyed 555 insurers across the nation, approximately 85% of the insurance market, on their responses to climate change.
 - Performed early intervention with a failing \$300 million domestic property and casualty insurer, resulting in 100% protection of injured workers' claims and the transfer of policies and claims to a healthy third party insurer.

Consumer Services

- Recovered over \$54 million for consumers as a result of investigations of consumer complaints received by the Department's consumer hotline and through market conduct examinations of insurance companies by the Department.
- Handled approximately 200,000 consumer calls to our Consumer Hotline.
- Collected \$740 million of reinsurance recoveries, reinsurance commutations and litigation recoveries of failed insurance companies to repay policyholders and creditors.
- Distributed \$865.9 million to injured policyholders and guaranty associations of failed insurance companies.

Community Programs

- Increased insurer investments in underserved communities in California through the department's COIN (California Organized Investment Network) Program from \$1.65 million in 2010 to \$23.58 million in 2011.
- Established an Insurance Diversity Task Force to advise and make recommendations on best practices in diversity in the insurance industry, including the diversity of corporate governing boards and procurement from diverse businesses.

Licensing

- Issued and renewed nearly 200,000 insurance agent and broker licenses, and completed review of over 3,000 insurance policy filings.
- Restricted or suspended the licenses of 565 agents and brokers.

Funding

- Collected \$2.3 billion in premium taxes for the state's General Fund.
- Contributed \$20 million in fines and penalties to the state's General Fund through the dedicated work of the department's Enforcement Branch.

The California Department of Insurance will continue to aggressively pursue our mission *"to ensure vibrant markets where insurers keep their promises and the health and economic security of individuals, families, and businesses are protected."*

Sincerely,

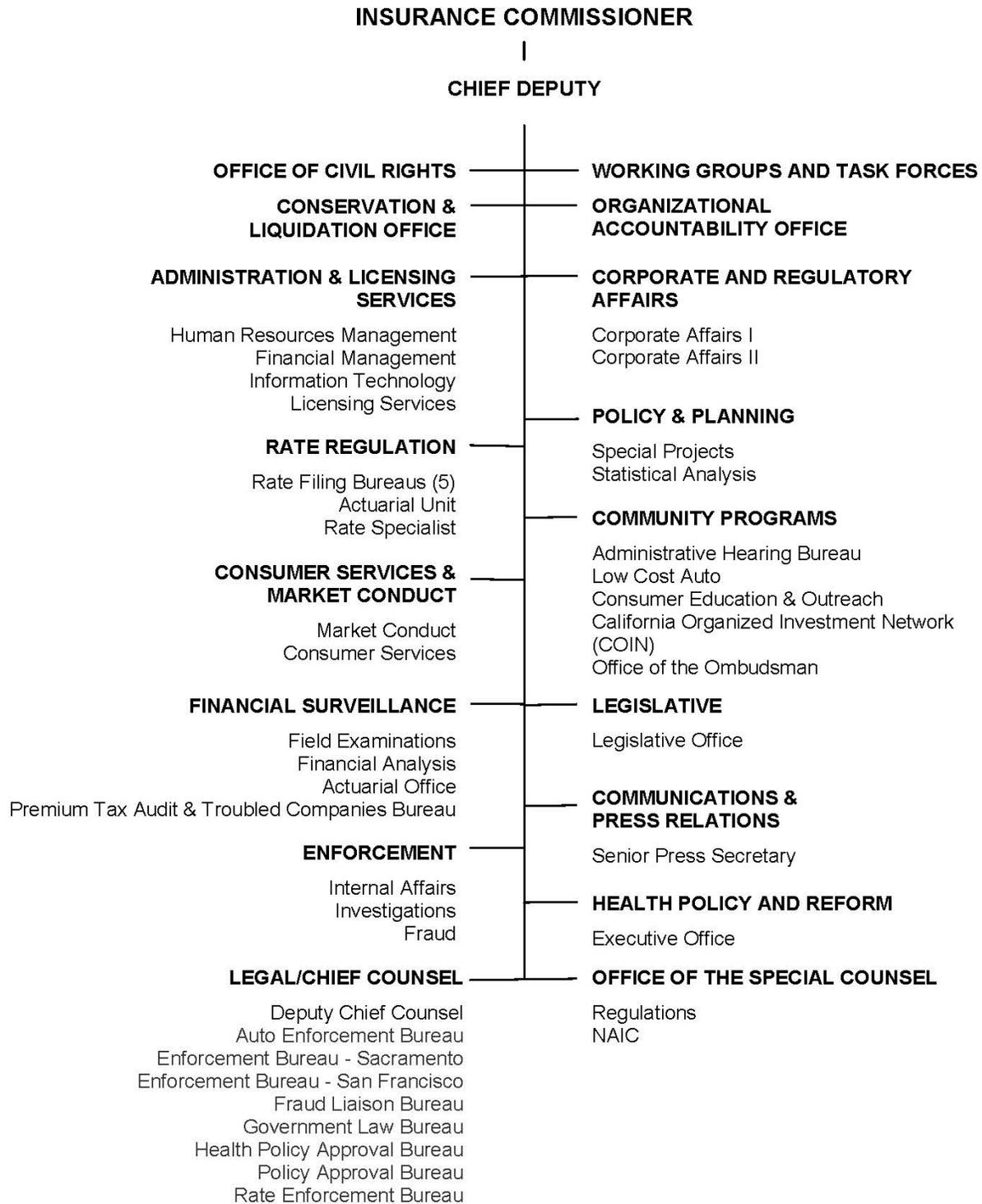


DAVE JONES

Insurance Commissioner

CC: Ron Calderon, Chair of the Insurance Committee, California State Senate
Jose Solorio, Chair of the Insurance Committee, California State Assembly
E. Dotson Wilson, Chief Clerk, California State Assembly
Diane F. Boyer-Vine, Legislative Counsel
Gregory Schmidt, Secretary of the Senate

California Department of Insurance
2011 Organizational Chart (Graphical Version)



California Department of Insurance 2011 Organizational Chart (Accessible Text Version)

INSURANCE COMMISSIONER

- CHIEF DEPUTY
 - OFFICE OF CIVIL RIGHTS
 - CONSERVATION & LIQUIDATION OFFICE
 - WORKING GROUPS AND TASK FORCES
 - ORGANIZATIONAL ACCOUNTABILITY OFFICE

ADMINISTRATION & LICENSING SERVICES

- Human Resources Management
- Financial Management
- Information Technology
- Licensing Services

RATE REGULATION

- Rate Filing Bureaus (5)
- Actuarial Unit
- Rate Specialist

CONSUMER SERVICES & MARKET CONDUCT

- Market Conduct
- Consumer Services

FINANCIAL SURVEILLANCE

- Field Examinations
- Financial Analysis
- Actuarial Office
- Premium Tax Audit & Troubled Companies Bureau

ENFORCEMENT

- Internal Affairs
- Investigations
- Fraud

LEGAL/GENERAL COUNSEL

- Deputy Chief Counsel

- Auto Enforcement Bureau
- Enforcement Bureau - Sacramento
- Enforcement Bureau -San Francisco
- Fraud Liaison Bureau
- Government Law Bureau
- Health Policy Approval Bureau
- Policy Approval Bureau
- Rate Enforcement Bureau

CORPORATE AND REGULATORY AFFAIRS

- Corporate Affairs I
- Corporate Affairs II

POLICY & PLANNING

- Special Projects
- Statistical Analysis

COMMUNITY RELATIONS

- Administrative Hearing Bureau
- Low Cost Auto
- Consumer Education & Outreach
- California Organized Investment Network (COIN)
- Office of the Ombudsman

LEGISLATIVE

- Legislative Office

COMMUNICATIONS & PRESS RELATIONS

- Senior Press Secretary

HEALTH POLICY AND REFORM

- Executive Office

OFFICE OF THE SPECIAL COUNSEL

- Regulation
- NAIC

2011 ANNUAL REPORT

**CONSUMER SERVICES *and* MARKET
CONDUCT BRANCH**

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Consumer Services & Market Conduct Branch

The Consumer Services and Market Conduct Branch's (CSMCB) focus is consumer protection, and it accomplishes this by educating consumers, mediating consumer complaints, and enforcing insurance laws. CSMCB enforces insurance laws during the investigation of individual consumer complaints against insurers and agents/brokers and through on-site examinations of insurer claims and underwriting files.

CSMCB consists of two divisions and six bureaus:

Consumer Services Division (CSD)

- Consumer Communications Bureau (CCB)
- Claims Services Bureau (CSB)
- Health Claims Bureau (HCB)
- Rating and Underwriting Services Bureau (RUSB)

Market Conduct Division (MCD)

- Field Claims Bureau (FCB)
- Field Rating and Underwriting Bureau (FRUB)

Table A: CSMCB 2011 Calendar Year Results

Consumer Telephone Calls Received (automated call-center calls)	181,144
Complaint Cases Opened	34,219
Complaint Cases Closed	35,490
Total Amount of Consumer Dollars Recovered	\$49,354,302
Number of Market Conduct Exams Adopted by the Commissioner	114
Total Amount of Claims Dollars Recovered or Premium Returned to Consumers from Market Conduct Exams	\$ 4,879,638
CSMCB Grand Total Amount (Consumer Dollars Recovered, Claims Dollars Recovered or Premium Returned to Consumers, and Penalties Resulting from Legal Actions in 2011)	\$ 54,236,940

CONSUMER SERVICES DIVISION

The Consumer Services Division (CSD) is responsible for responding to consumer inquiries and complaints regarding insurance company or producer activities. CSD maintains separate bureaus to handle telephone inquiries and provide education to the public, respond to consumer complaints on claims handling practices, respond to rating and underwriting based consumer complaints, and to provide education to the public on insurance issues. The goal of CSD is primarily to protect California insurance consumers through enforcement of the California Insurance Code and related laws and regulations.

The CSD is responsible for administering the program described in California Insurance Code (CIC) Section 12921.1(a), for investigating complaints, responding to consumer inquiries and bringing enforcement actions against insurers and production agencies.

In accordance with California Insurance Code (CIC) Section 12921.1(a)(10), the Department is reporting a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the Department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation (if any) to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the Department pursuant to complaints if further enforcement is deemed necessary to ensure proper compliance by insurers or production agencies with the law.

Complaints and inquiries are handled by four bureaus within the division: the Consumer Communication Bureau (CCB), the Claims Services Bureau (CSB), the Health Claims Bureau (HCB), and the Rating & Underwriting Services Bureau (RUSB). In 2011, 109 fulltime staff were devoted to the complaint handling operation. This represents 8 percent of the 1,336 total authorized positions in the Department.

- The CCB Hotline staff answers questions on insurance claims and underwriting practices, administers the CDI Residential, Earthquake and Automobile Mediation Programs, and handles time sensitive complaints.
- CSB is responsible for investigating, evaluating, and resolving consumer complaints involving claims issues for all lines of insurance except Workers' Compensation, which is regulated by the Department of Industrial Relations in California, and health.
- HCB is responsible for investigating, evaluating, and resolving consumer complaints involving health claims issues and administers the Department's Independent Medical Review program mandated by CIC 10169.
- RUSB is responsible for investigating, evaluating, and resolving consumer complaints involving rating and underwriting issues for all lines of insurance (including Workers' Compensation). Consumers may file complaints via telephone, internet or in written correspondence.

The review and initiation of the investigation of complaints occurs within three days of receipt, and the CDI contacts the appropriate licensees (insurers or agents). The time needed to resolve a complaint varies in accordance with the type of case and the

complexity of the issues to be evaluated and resolved. The average time among all cases is about 45 days from open to close. Complex cases involve analysis of conflicting facts and applicable laws. Resolution in such cases may require more lengthy investigation. Conversely, cases involving less complex issues may be resolved within hours, days, or a few weeks. Consumers are informed about the final resolution of complaints as quickly as possible, but no later than 30 days after the final action.

Disaster Response: In addition to the complaint handling operation of the Department, the Consumer Services Division also coordinates the Department’s response to natural and other disasters that impact insurance consumers and businesses in California. This response includes administration of the Emergency Damage Assessment function described in CIC Section 16000.

The Consumer Services Division monitored approximately 13 disaster events in 2011 as follows: 1 Earthquake, 1 winter storm, 2 Tsunami warnings and 9 wildfires. Among the events that resulted in notable damages are the Los Angeles County High Winds in the Pasadena and surrounding communities as well as the Kern County fires. The Division deployed 1 Officer from CSD to assist CalEMA at the Local Assistance Center in Kern County.

Consumer Complaint Trends: The following tables identify notable complaint trends by line of coverage:

Table B: Trends in Percentage of Complaints by Lines of Coverage

Coverage Type	2005	2006	2007	2008	2009	2010	2011
AUTO	40.36%	40.13%	37.77%	34.43%	33.76%	31.01%	33.08%
ACCIDENT & HEALTH	22.16%	25.91%	30.42%	31.76%	31.29%	37.00%	35.11%
MISC./ OTHER	15.00%	13.93%	13.12%	12.90%	13.66%	12.34%	12.11%
HOMEOWNERS	9.62%	7.41%	7.16%	8.80%	8.48%	8.29%	8.40%
LIFE & ANNUITY	6.98%	7.23%	6.80%	7.23%	7.49%	6.52%	6.59%
LIABILITY	2.85%	2.82%	2.34%	2.43%	2.54%	2.09%	1.96%
FIRE, ALLIED LINES & CMP	2.28%	1.90%	1.61%	1.82%	2.05%	2.09%	2.47%
EARTHQUAKE	0.48%	0.27%	0.28%	0.36%	0.43%	0.38%	0.28%

Table C: Top Ten Types of Complaint Reasons (2006-2011)

#	Types of Complaint Reasons	2006	2007	2008	2009	2010	2011
1	Denial of Claim	24%	24%	25%	26%	26%	26%
2	Unsatisfactory Settlement Offer	16%	15%	12%	13%	13%	13%
3	Claim Handling Delay	15%	15%	13%	13%	13%	11%
4	Other - Claim Handling	4%	5%	6%	6%	6%	4%
5	Premium & Rating / Misquotes	5%	5%	6%	5%	8%	7%
6	Premium Refund	5%	5%	5%	4%	4%	4%
7	Coverage Question	4%	4%	4%	3%	3%	3%
8	Cancellation	3%	3%	3%	3%	3%	3%
9	Agent Handling	3%	3%	3%	3%	3%	3%
10	Premium Notice/Billing Problem	3%	3%	3%	2%	3%	3%
	All Other Reasons	18%	18%	21%	22%	18%	23%

Consumer Communications Bureau

The Consumer Communications Bureau (CCB) Consumer Hotline is often referred to as the Commissioner's "eyes & ears" on the issues and concerns that affect California's insurance consumer. CCB officers respond to phone calls received through the California Department of Insurance's (CDI) statewide toll-free Consumer Hotline, 800-927-HELP (4357), to provide callers with immediate access to constantly updated information on insurance related issues. The Hotline is staffed by knowledgeable insurance professionals whose years of expertise, combined with their dedication to consumers, enables them to provide immediate assistance on time sensitive issues. CCB also responds to inquiries received through the Consumer "Contact Us" Web site; coordinates responses to inquiries addressed to the Commissioner through its Commissioner's Correspondence Unit; responds to "walk-in" inquiries at the Department's Los Angeles public counter; leads the CSD Health Triage Team; organizes the CSD Inter-Agency Health Team; analyzes and provides input on proposed legislation; manages the Division's Disaster Response Program, and leads or participates in various task forces.

Residential Property, Earthquake, and Automobile Physical Damage Mediation Program

CCB administers the Department's Residential Property, Earthquake Claims, and Automobile Physical Damage Mediation Program. The program was established in 1995 in response to earthquake claims resulting from the Northridge Earthquake of January 17, 1994. The legislature has since expanded the program to include automobile physical damage and residential property disputes subject to specific guidelines. Since the program's inception in 1996 through December 31, 2011, the Mediation Program has recovered \$17,899,044 for consumers. In accordance with CIC 10089.83, the following is a report of the results of the program for the calendar year 2011.

Table D: 2011 Residential Property, Earthquake, and Automobile Mediation Program Results

	Residential	Earthquake	Automobile	Totals
Number of mediation cases eligible	8	0	3	11
Number settled within 28 day settlement period	0	0	0	0
Number sent to mediation	3	0	1	4
Number of cases rejected by insurer	2	0	1	3
Number accepted by insurer	3	0	1	4
Number of settlements rejected within 3 day waiting period	0	0	0	0
Amount initially claimed	\$975,914.66	0	\$18,342.00	\$994,256.70
Amount of settlements	\$591,863.14	0	\$15,698.00	\$607,559.10

Claims Services Bureau

The Claims Services Bureau (CSB) investigates consumer allegations of improper claims handling by insurers. These written requests for assistance include, but are not limited to, wrongful denial of claims, payments less than amounts claimed, and delays in claims handling. If its investigation indicates a violation of an insurance law or regulation has occurred, CSB pursues payment of claims that were improperly denied or delayed, when applicable.

Health Claims Bureau

The Health Claims Bureau (HCB) investigates consumer and health care provider allegations of improper handling of health insurance claims by insurers. These requests for assistance include, but are not limited to, wrongful denial of claims, payments of less than amounts claimed and delays in claims handling. HCB works with the complainant to clarify issues and reach a resolution with the insurer. If the investigation shows that an insurance code or regulation has been violated or the policy contract has not been honored, HCB will enforce the code, regulation or policy contract which will often result in a favorable outcome for the consumer.

The Health Claims Bureau also administers the Independent Medical Review (IMR) program which determines if a denial by an insurer, based on the treatment being experimental, investigational or not medically necessary, should be overturned or upheld. This includes determining which complaints qualify for the program, guiding the

consumer through the IMR process, working with the IMR organization, communicating the final decision to all parties, and developing statistics related to IMR results which are available to consumers on the Department's public website.

Health Care Provider Bill of Rights Report

In accordance with California Insurance Code Section 10133.65, the Department reports that no complaints involving this section of the insurance code were received for calendar year 2011.

Rating and Underwriting Services Bureau

The Rating and Underwriting Services Bureau (RUSB) investigates consumer complaints of improper or inequitable rating and underwriting transactions performed by insurance companies and agents/brokers. RUSB works with the affected parties to clarify issues and reach a resolution. When RUSB's investigation shows that an insurance violation or a policy breach has occurred, RUSB enforces the code or policy contract and requires the reinstatement of coverage and the refunding of premiums and broker fees, when applicable.

In addition to assisting consumers with a variety of issues involving all lines of insurance, RUSB also participates on the Senior Issues Working Group and the Disability Advisory Committee, and assists people impacted by wildfires and other catastrophic events at local assistance centers and workshops. RUSB produces detailed trend and hot topics reports on insurance company and agent/broker violations identified from its review of consumer complaint files which CSMCB and others within the Department find valuable in identifying and monitoring non-compliant activity by licensees.

(CIC) Section 1858.35 Report

In accordance with California Insurance Code (CIC) Section 1858.35, the Department is reporting the number and type of complaints received by the Department from any person aggrieved by any rate charged, rating plan, rating system or underwriting rule, and the disposition of these complaints.

Table E: (CIC) Section 1858.35 Complaints by Type/Reason 2011

Rank	Complaint Type/Reason	# of Complaints
1	Premium & Rating Misquotes	786
2	Coverage Question	383
3	Premium Notice/ Billing Problem	301
4	Non-Renewal	263
5	Surcharge	242
6	Premium Refund	228
7	Cancellation	221
8	Agent Handling	133
9	OTHER	66
10	Escrow Handling	40
11	Policyholder Service Delays No Response	35
12	Other-Policy Holder Service	35
13	Information Requested	27
14	Delay/Failure To Respond	17
15	Refusal To Insure	15
	All Other Reasons	135
	TOTAL	2,927

Table F: (CIC) Section 1858.35 Complaints by Final Disposition 2011

Rank	Final Disposition	# of Complaints	Recovery Amount
1	Company Position Upheld	1290	\$7,564
2	Advised Complainant	269	1,804
3	Refund	243	173,159
4	Company in Compliance	176	1,139
5	Other	142	1,605
6	Information Furnished/Expanded	130	5,242
7	Question of Fact	99	1,561
8	Premium Problem Resolved	77	6,257
9	Recovery	65	128,940
10	No renewal Upheld	50	0
11	Policy Not in Force	49	768
12	Compromised Settlement/Resolution	46	9,963
13	Policy Issued/Restored	44	21,903
14	Nonrenewal Notice Rescinded	44	10,486
15	Coverage Extended	35	118,342
	All Other Disposition Codes	164	24,056
	TOTAL	2,923	\$512,789

California Insurance Code (CIC) § 1707.7 (d) Report

In accordance with California Insurance Code Section 1707.7(d), the Department reports that there were 660 justified complaints against licensees outlined in 1707.7(b) for the year 2009, 870 justified complaints for 2010 and 887 for 2011.

Market Conduct Division

The Market Conduct Division (MCD) is responsible for the examination of insurance company practices on behalf of the California Department of Insurance. These examinations are generally based on a fixed schedule of examinations, scheduled re-examinations and targeted examinations due to special circumstances or the results of market analysis of consumer complaints and other data. Depending upon their size, complexity, and nature, exams are either conducted in the insurers' offices, located nationwide or in-house at the CDI's offices, with insurers shipping materials and files to our staff.

MCD maintains separate bureaus to conduct claims handling practices exams and rating and underwriting exams, a reflection of a division of operations in the insurance industry and in the laws regulating claims from rating practices. Also in MCD, the Market Analysis Unit evaluates consumer complaints, enforcement actions, exam activity, and other data on a national basis to identify issues that may be of regulatory concern in California. The goal of any market conduct examination is to evaluate compliance with statutes and regulations relative to the business of insurance and to initiate corrective or enforcement actions when necessary.

The following is a summary of MCD's accomplishments for the year 2011. The list covers different areas of accomplishment, including exams completed, dollars returned to consumers, industry and community interactions, and legal actions taken.

Table G: Market Conduct Division Results for 2011

Examination Results Category	FCB*	FRUB**	MCD Totals
Number of Exams Adopted by the Commissioner	53	61	114
Amount of Claims Dollars Recovered or Premium Returned to Consumers	\$892,339	\$3,987,299	\$4,879,638

* **FCB:** Field Claims Bureau

** **FRUB:** Field Rating & Underwriting Bureau

Field Claims Bureau

The Field Claims Bureau (FCB) conducts market conduct examinations of the claims practices of all licensed California insurers. The focus of each exam is on compliance with the California Insurance Code and the California Fair Claims Settlement Practices regulations. FCB seeks to ensure equitable treatment of policyholders and claimants in

accordance with insurance contracts and California law. The California Insurance Code sections cited in FCB examinations vary by line of insurance. However, those that are common to both life & disability and property & casualty insurance involve delay, documentation, and improper handling, which may include improper settlement, failure to pursue investigation, and improper denial. FCB obtains thousands of remedial claim actions from insurers each year as a result of the examinations it conducts. Many of the issues which lead to these actions are displayed in its reports which are published on the Department's website. During calendar year 2011, Field Claims Bureau staff examined 6,241 claim files and cited 3,142 violations of law in the reports it filed.

Field Rating and Underwriting Bureau

The Field Rating and Underwriting Bureau (FRUB) conducts market conduct examinations of the rating and underwriting practices of all licensed insurers. FRUB reviews the advertising, marketing, risk selection and declination, underwriting, pricing, and policy termination practices of life, health, property, and casualty insurers. FRUB examinations focus on compliance with rate filing requirements, consistency within the insurer's adopted rating processes, and overall conformity of rating and underwriting with the California law. Each year, as a result of the examinations it conducts, FRUB obtains remedial actions from insurers in the form of revisions to incorrect and illegal practices and premium refunds to consumers when errors and violations resulting in premium overcharges are discovered. During calendar year 2011, Field Rating and Underwriting Bureau staff examined 2,033 policy files resulting in the identification of 249 illegal practices for correction in the reports it filed.

California Insurance Code (CIC) § 12921.4(b)

In accordance with California Insurance Code (CIC) § 12921.4(b), the Market Analysis Unit reviewed the complaint data of each insurance carrier that was authorized to transact business in the State of California during the year 2011. The analysis of complaint data focused on the following areas: insurer, insurance line of business, and type of violation.

Complaint totals by insurer is one of the primary criteria for determining the Market Conduct Division's examination schedule. The ten insurers with the most closed complaints in 2011 (ranging from 445 for the bottom company to 2,094 for the company at the top) have all been examined within in the last 3 years or are scheduled to be examined in the next 2 years (2 completed, 4 in progress, 4 on schedule). Additionally, several of the insurers identified with high complaint totals have been examined more than once during the 5 year timeframe. Six of the ten companies with the most closed complaints have been the subject of enforcement actions within the last 3 years.

Complaints by line of business continue to be an important area for focusing Market Conduct Division examination resources. The top five lines of business which generated the most complaints were the following: private passenger auto (11,589), group accident and health (7,326), individual accident and health (4,768), homeowners (2,629), and individual life (1,898). These lines of business were among the most frequently examined by both the Field Claims Bureau and the Field Rating and Underwriting Bureau during 2011. Within each line of business, the Market Conduct Division also prioritizes those insurers with the most complaints. All insurers in the top

10 of complaints in each line have been examined in the last 3 years or are scheduled to be examined in the next two years. Thus, the lines of business most impacted by complaints, and the insurers that generated the most complaints within those lines of business, are prioritized for examination by the Market Conduct Division.

An analysis of complaints sorted by the type of violation is completed for each examination initiated for the Market Conduct Division. The results of this analysis allow the examiners in charge to identify areas of their review that they should scrutinize more closely. Whenever a trend or pattern in violation data is observed, the information is shared with those Department employees that have a use or need for the data.

A geographic analysis, established by zip code, of consumer complaints was conducted for the year 2011. Complaints within those geographic regions identified as having high concentrations of complaints relative to the population of the region will be the subject of further analysis during 2012.

2011 ANNUAL REPORT
**HEALTH POLICY *and* REFORM
BRANCH**

Health Policy and Reform Branch: Implementing the Affordable Care Act

Background

The Patient Protection and Affordable Care Act (PPACA), otherwise known as federal healthcare reform, was passed by Congress and signed into law by President Obama on March 23, 2010. As the regulator of the health insurance industry, the California Department of Insurance (CDI), plays a significant role in PPACA implementation and is working with state and federal agencies to ensure that reforms both expand health care coverage and protect consumers.

This federal law has the opportunity to bring health insurance coverage to millions of Californians, which is a top priority for the CDI. In 2011, the Commissioner tasked the Department with working towards fully implementing the PPACA in California. Many significant provisions of this federal law have already come into effect – others come into effect by January 1, 2014. During the 2010 legislative session, the California State Legislature enacted a number of laws that both mirror and exceed the requirements of the federal law, making California a national leader in ensuring more accessible and affordable health care coverage for all.

Implementing the Affordable Care Act

The PPACA created a multitude of changes, both changes to the health insurance marketplace in California as well as direct regulatory requirements on CDI. In 2011, CDI worked towards adapting its regulation of the California health insurance industry to accommodate these marketplace changes. In addition, many of the federal PPACA changes were incorporated into legislation passed during the 2010 legislative session, including establishing the California Health Benefit Exchange, ensuring rate review of health insurance premiums, preventing insurers from denying coverage to children with pre-existing conditions and prohibition of cancellation, non-renewal, or rescission of coverage under many circumstances.

With the passage of PPACA, there are many reforms that the Department must implement and enforce. The significant and structural changes that have taken effect in 2011-12, as well as future reforms that take effect in upcoming years, have required a more robust framework of legal and policy support within the CDI. This extra support has helped the department effectively work towards implementation of the federal reform requirements, integrate federal and state changes to the marketplace, increase coordination across state agencies, and actively represent California insurance consumers with the federal government and the National Association of Insurance Commissioners (NAIC), which has been delegated the responsibility by the federal government to assist states with PPACA implementation and guidance.

Nevertheless, several federal regulations that establish the scope of health reform implementation have yet to be finalized. The CDI has spent the past year working with

NAIC, Insurance Commissioners in other states, and the federal Department of Health and Human Services on the development of proposed federal regulations that California will be subject to and expects to be engaged in this work at least through 2015.

Accomplishments

Issued Regulations, Sponsored Legislation and Implemented Medical Loss Ratio Requirement

Under PPACA, as of January 1st, 2011, health insurers in the individual market are required to maintain a medical loss ratio of 80%. Insurance Commissioner Dave Jones issued an emergency regulation the evening he was sworn in (January 3, 2011) authorizing him to enforce the 80% Medical Loss Ratio (MLR) established under the Patient Protection and Affordable Care Act (PPACA) for health insurance sold to individuals. The Office of Administrative Law (OAL) approved Insurance Commissioner Jones' emergency regulation. The MLR is defined as the percentage of premium revenues an insurer pays for medical services, as opposed to insurer profits, marketing, and overhead.

Commissioner Jones and the Department then sponsored and obtained enactment of SB 51 (Alquist) to codify in state law the federal MLR standard of 80% for the small group market segment and 85% MLR for the large group market.

Since January 1, 2011, the Department has enforced this critically important component of PPACA which ensures that a larger share of the premiums collected by health insurers pay for actual medical care.

Established Guidance for Rate Review

In 2011, attorneys in the Health Policy Approval Bureau developed guidelines issued by the Commissioner (known formally as Guidance) to implement the provisions of health reform legislation enacted in 2010. This included a series of Guidance documents establishing requirements and forms for the filing of health insurance rate submissions in the individual and small group market, specifying the requirements for the actuarial memoranda submitted with rates, and describing a number of factors that are considered by the Department in determining whether a new rate or a rate increase is unreasonable.

Secured Funding for Rate Review Functions

In fall of 2011, the Department joined the Department of Managed Health Care (DMHC) in obtaining an award of approximately \$4.3 million in federal grant money to implement parts of the Affordable Care Act that related to health insurance and HMO rate review. According to the U.S. Department of Health and Human Services (HHS), California is one of 28 states and the District of Columbia that received rate review grant funds.

California received this funding as part of the Cycle II Rate Review Grant awards, which includes \$1.24 million given to larger states with higher workloads. But states with prior

approval authority over rates received an additional \$600,000. Since California does not have the authority to disapprove excessive rates ("prior approval") it was not awarded the additional funds.

The Department of Insurance is using this funding for the following purposes:

- Expanded scope of rate review - Newly-hired staff helped to shorten the time it takes for reviewing rates, issuing final determinations, and posting and reporting the determinations.
- Improved transparency and consumer interfaces - Providing \$75,000 per year (for three years) in grants to consumer advocacy groups to review rate filings and submit comments to the Department to help improve public input in the rate evaluation process.

While the federal grant funding is important, California's continued lack of legal authority to reject excessive health insurance and HMO rate increases continues to cost California's consumers and businesses hundreds of millions of dollars in excess premiums. Thirty-four other states have the authority to reject excessive health insurance and HMO rate hikes. Commissioner Jones authored three bills while in the State Legislature and sponsored a fourth bill, AB 52 (Feuer) as Insurance Commissioner, which would authorize rejection of excessive health insurance and HMO rate hikes. The lack of authority to reject excessive health insurance rate hikes is a major missing piece of federal and state healthcare reform.

Issued Regulations for Children's Health Insurance

The Health Policy and Reform Branch oversaw development of regulations issued by the Insurance Commissioner to implement another important benefit of federal health care reform – the requirement that health insurers provide health insurance to children even if they have a pre-existing condition. It used to be health insurers could deny children health insurance if they had a pre-existing condition.

Issued Regulations for Medical Rescissions

The Health Reform and Policy Branch oversaw the development of regulations issued by the Insurance Commissioner preventing "medical rescissions" and establishing a notice and hearing process for consumers.

Health Insurance Policy Approval

The Department reviewed more than 150 health insurance policy forms for compliance with new benefit design and cost sharing requirements, such as the elimination of lifetime limits on benefits and the elimination of co-payments and co-insurance requirements for preventative services.

Improved Consumer Outreach

- Updating the Department's consumer brochure about health insurance. The brochure updates provide more information to consumers to answer questions they may have about seeking or using health insurance and to provide information about recent changes in state and federal law that impact consumers
- Updating the Department's public website to be more consumer friendly and informative about changes in the law relating to health insurance.

Trainings for CDI staff (policy reviewers, consumer hotline, market conduct, field examiners, etc.) with updates to federal and state health care reform

The Health Policy and Reform Branch provided training to other CDI staff and components regarding both federal and state healthcare reform efforts.

Provided policy, legal and technical support to the Legislature and State and Federal Agencies regarding PPACA implementation

The Health Policy and Reform Branch provided policy, legal and technical support to the California Legislature, the State Health and Human Services Agency, the California Exchange Authority, Federal Health and Human Services Department, and other agencies.

Worked Within National Association of Insurance Commissioners to Implement PPACA

PPACA specifies the NAIC as the entity responsible for developing definitions, guidelines, or model laws as the basis of further HHS regulations. The Health Policy and Reform Branch staffed the Department's activity within the NAIC to implement PPACA, including but not limited to the following:

- Continued analysis regarding components of the federal definition medical loss ratio, the basis of the federally-required 80% (for individual policies) and 85% (for group policies) loss ratio/refund requirements;
- Planning, evaluating, and monitoring of the implementation of the MLR regulations;
- Monitoring and actively participating in weekly NAIC PPACA implementation conference calls;
- Determining when data calls are required for monitoring of implementation;
- Analyzing market disruption resulting from implementation of MLR to provide recommendation to the Insurance Commissioner regarding application of federal waiver of PPACA MLR requirements;
- Analyzing results of data calls;
- Creating required state/federal reports;

- Provide comments to federal government regarding interim federal regulations, and to also shape the further development within federal HHS of additional, future guidance on implementation of PPACA.



2011 ANNUAL REPORT
RATE REGULATION BRANCH



Rate Regulation Branch

The Rate Regulation Branch (RRB) analyzes filings submitted by property and casualty insurers and other insurance organizations under California's prior approval statutes for most property and casualty lines of business. In addition, the RRB analyzes filings submitted by property and casualty insurers and other insurance organizations under California's file and use statutes for a limited number of property and casualty lines of business. The passage of Proposition 103 in 1988 required the RRB to begin reviewing rates for most property and casualty lines of business before property and casualty companies could use them. This process, mandated by the California Insurance Code (CIC) Section 1861.05, requires the RRB to ensure that the rates contained in an insurer's filing are not excessive, inadequate or unfairly discriminatory prior to those rates being approved for use by the insurer.

One major focal point from 2011 was on medical malpractice insurance. Commissioner Jones required six of the largest medical malpractice insurance companies in California to submit rate filings to the Department of Insurance to justify their current rates. After careful review of those filings, Rate Regulation determined the rates were excessive and required all six companies to substantially lower their medical malpractice insurance rates for a total annual savings to medical providers of nearly \$44 million. The process was completed in early 2012. Under the authority granted to the Commissioner by Proposition 103, the Department processed close to 8,000 property-casualty rate, rule and form filings during 2011 and reduced the overall amount of requested rate increases by \$51 million while approving rate reductions totaling over \$398 million. This includes \$8.7 million in reduced rate increases and over \$105 million in approved rate decreases for personal auto coverage.

Commissioner Jones has directed Rate Regulation to focus attention on the rates charged for force-placed property coverage in 2012 among its other responsibilities.

Rate Filing Bureaus

The Rate Regulation Branch has five (5) filing bureaus (two in San Francisco and three in Los Angeles) that receive and review filings from over seven hundred fifty (750) property and casualty companies licensed in the state. The Intake Unit in the San Francisco office is responsible for processing all filing applications, except for Workers' Compensation and Title companies, and providing copies of all filings to the Public Viewing Rooms maintained in San Francisco and Los Angeles for public access. RRB also has an Actuarial unit and in 2008, the Rate Specialist Bureau (RSB) was also reassigned back to the RRB. RSB provides technical advice and support with regard to underwriting, rating, data collection, statistical analysis, profitability, and rate-of-return issues for all lines of insurance.

In conjunction with the National Association of Insurance Commissioners (NAIC), Rate Regulation is actively promoting its participation in the System for Electronic Rate and Form Filings (SERFF) project. This system is designed to enable companies to send and states to receive, comment on, approve or reject insurance industry rate and form filings. The electronic aspects of this project will help increase efficiency and facilitate communication between the Rate Filing Bureaus and insurers. The percentage of

filings received via SERFF continues to increase each year. During 2011, the percentage of total filings received through SERFF increased to ninety five percent (95%), up from eighty four percent (84%) in 2010.

In addition to prior approval filing applications, the Rate Filing Bureaus are responsible for the review of other required filings as follows:

Private Passenger Auto Class Plans – California Department of Insurance regulations require all insurance companies writing private passenger automobile insurance to submit a Classification Plan (Class Plans). Class Plans provide the Department with the rating methodology each company will develop or adopt in order to comply with the provisions of Proposition 103 that mandate the use of certain specific rating factors.

Advisory Organizations – California Insurance Code Section 1855.5 requires that all policy or bond forms, and manuals, intended for use by members of an advisory organization must first be filed with the Commissioner for review and approval prior to being used by member insurance companies.

Workers' Compensation – In 1993 and 1994, the workers' compensation minimum rate law was replaced with a competitive rating system which took effect in 1995. Under the competitive rating law, codified in California Insurance Code Section 11735, insurers are free to develop their own rates based on advisory pure premiums (loss costs) and company-developed loss cost multipliers. However, all company rates, rating plans, and rating rules must be filed with the Rate Regulation Branch prior to use. In 2011, four hundred and ninety one (491) workers' compensation rate filings were reviewed.

Title Insurance – California Insurance Code Section 12401.1 requires title insurers and underwritten title companies to file their title and escrow rates with the Department prior to their use. In 2011, seventy six (76) title insurance rate filings were reviewed.

Types of Filings Received During 2010 and 2011	2011	2010
Private Passenger Automobile	644	516
Homeowners	209	296
Other Personal Lines Products	340	346
Title	76	138
Workers' Compensation	491	540
Medical Malpractice	72	46
Other Commercial Lines Products	6,092	5,196
Total	7,924	7,079

Rate Specialist Bureau

The Rate Specialist Bureau (RSB) provides advice and support to the Insurance Commissioner, executive staff, other CDI Branch Managers, and the insurance industry/consumers with regard to underwriting, rating, data collection, statistical

analysis, profitability, and rate-of-return issues. RSB's duties and responsibilities continue to include all lines of insurance. The following is a list of projects and duties handled by RSB in 2011:

1. Assisted the Prior Approval Working Group with regard to the preparation of key rate components for the prior-approval regulations. In support of the regulation, RSB promulgated supporting data and reports that were used by the CDI and the rate analysts in the review of rate filings for Proposition 103 lines of insurance. Report topics included: Efficiency Standards; Leverage Factors by line; Reserve Ratios; Industry Rate-of>Returns; Projected Yields; Investment Income; CPI Index for expense trend factors; the Federal Income Tax rate on investment income; California and Countrywide Profitability; and Risk Based Capital.

Collected Bond Yields information on a daily basis and compiled information from various sources for the calculation of risk free rates, investment yield rates, and projected yield. This information is published monthly in the CDI website for use by the companies in their rate filings.

1. Conducted the Survey of Marketing System Information to collect data in order to update the calculation of efficiency standards.
3. Compiled California Market Share Reports for Property & Casualty insurance, for Life & Annuity insurance, for Title and for Home Warranty. Also compiled: Directory of all California licensed insurers and their Annual Statement state page data; summaries of the Investment Schedules for California licensed P&C insurers; and the Supplemental Executive Compensation Exhibits data.
4. Compiled data for the Excessive Rate Monitoring Project for the Rate Filing Bureaus and executive staff. Using information obtained from RSB's Market Share and Efficiency Standards Reports, RSB expanded its excessive rate monitoring project of homeowners' and personal automobile insurance to include: fire and allied lines, commercial multi-peril programs, farmowners', medical professional liability, commercial auto, inland marine, credit, burglary and theft, and financial guaranty.
5. Completed various projects in relation to workers' compensation insurance such as preparing market share reports and historical premium, loss and dividend comparisons, and compiling the Workers' Compensation Insurance Rate Comparison for CDI's website.
6. Promulgated the Proposition 103 Administration Fees for property & casualty companies, and the workers' compensation filing fee charges for the Accounting Division.
7. Collected, compiled, and analyzed data as required by various sections of the California Insurance Code (i.e. child care liability, medical & legal professional liability). RSB also continued to collect Calendar Year 2010 loss and experience data of credit property and credit unemployment insurance pursuant to (CIC

§779.36, amended by Statute 199, Chapter 413, §1). The due date for the Child Care Report is May 1; the due date for the Legal and Medical Professional Liability Reports and the Credit reports is July 1. Due to resources constraints, collection of legal and medical malpractice data was suspended for 2011 per Insurance code section 11555.2.

8. Continued to collect and compile earthquake probable maximum loss (PML) data via the annual data calls which are due by June 30 from primary carriers and August 31 from reinsurers. RSB also collected and compiled the annual Earthquake Premium & Policy Count data call.
9. Continued to review Insurance Services Office (ISO) and National Association of Independent Insurers (NAII) submitted Fast Track data, and promulgated private passenger automobile and homeowners' insurance trend factors. RSB also compiled the commercial line fast track historical data, and was involved in other rate component determination research.
10. Acted as liaison to the California FAIR Plan Association. RSB's staff participated in the California FAIR Plan's rating and underwriting appeals proceedings and attended its Governing Committee meetings.

RSB is also responsible for reporting data under the following California Insurance Code (CIC) Sections:

- | | |
|---------------------|---|
| CIC §674.5 & 674.6: | Companies ceasing to offer a particular line of coverage |
| CIC §1857.9: | Special data call on classes of insurance designated by the Insurance Commissioner as unavailable or unaffordable |
| CIC §1864: | Child Care Liability Insurance |

CIC §674.5 & §674.6: COMPANIES CEASING TO OFFER A PARTICULAR LINE OF COVERAGE

Under CIC §674.5, an insurer ceasing to offer any particular class of commercial liability insurance must provide prior notification of its intent to the commissioner. Likewise, under CIC §674.6, an insurer offering policies of commercial liability and most types of property/casualty insurance, must provide prior notification to the commissioner of its intent to withdraw wholly or substantially from the specified line of insurance. The list of notifications that the Department received is shown on the next page.

CIC §1857.9: SPECIAL DATA CALL ON CLASSES OF INSURANCE DESIGNATED BY THE COMMISSIONER AS UNAVAILABLE OR UNAFFORDABLE IN CALIFORNIA

The Insurance Commissioner did not designate any classes of insurance in 2011.

Per CIC §674.5 & §674.6:

PRIOR WITHDRAWAL & CEASE-WRITING NOTICES RECEIVED DURING 2011

NAIC #	Company Name	Group Name	Request Date	Effective Date	Proposed Action by Company
18767	Church Mutual Insurance Company		1/21/2011	8/1/2011	Discontinue writing personal lines coverages.
37540	Beazley Insurance Co., Inc.		3/16/2011		Withdraw from mono-line commercial property market.
26433	Harco National Insurance Co.	IAT Reinsurance	5/2/2011		Cease offering commercial insurance to automobile dealers (selling both new and used passenger automobiles) in the State of CA.
20648	Employers' Fire Insurance Co.	White Mountains Group	6/27/2011	2/1/2012	Cease offering Managed Care Errors and Omissions Liability Insurance product.
21946	Camden Fire Ins. Association	White Mountains Group	9/21/2011		Cease writing business in CA to reorganize and consolidate underwriting companies. Atlantic Specialty Ins Co will be used as a lead company.
20648	Employers' Fire Insurance Co.	White Mountains Group	9/21/2011		Cease writing business in CA to reorganize and consolidate underwriting companies. Atlantic Specialty Ins Co will be used as a lead company.
38369	Northern Assurance Co. of America	White Mountains Group	9/21/2011		Cease writing business in CA to reorganize and consolidate underwriting companies. Atlantic Specialty Ins Co will be used as a lead company.
20621	OneBeacon America Insurance Co.	White Mountains Group	9/21/2011		Cease writing business in CA to reorganize and consolidate underwriting companies. Atlantic Specialty Ins Co will be used as a lead company.
21970	OneBeacon Insurance Company	White Mountains Group	9/21/2011		Cease writing business in CA to reorganize and consolidate underwriting companies. Atlantic Specialty Ins Co will be used as a lead company.
10847	CUMIS Insurance Society, Inc.	CUNA Mutual Group	11/3/2011		Cease renewing its commercial lines policies affording Equipment Maintenance Insurance coverage to financial institutions.
23469	American Modern Insurance Co.	Munich Group	11/8/2011		Discontinue writing RV insurance in CA.

CIC §1864: CHILD CARE LIABILITY INSURANCE

Section 1864 was added to the Insurance Code as of January 1, 1986. This section requires that on or before May 1 of each year, each insurer engaged in writing child care liability insurance in California submits a report of its child care liability premium and loss experience for the preceding calendar year. A call for the prescribed statistics is sent to all insurers licensed to transact liability insurance in California, and the reports are categorized by licensed Family Day Care (FDC) Homes and licensed Child Care (CC) Centers. FDC Home business is further broken into Small FDC Homes (licensed for 1 to 6 children) and Large FDC Homes (licensed for 7 to 12 children). Because of this data call's May 1 due date, at the time of the compilation of this Annual Report, the 2011 data was not yet available. The most current aggregate data is for calendar year 2010. Additional information will be posted on the Department's website.

For calendar year 2010, 29 property-casualty companies/groups admitted to do business in California submitted data under CIC §1864 requirements. Of the 29 insurers, 18 insurers submitted data for FDC Homes insured either on a separate liability policy or as an endorsement to the homeowners' policy. Twenty-three (23) insurers submitted data for licensed CC Centers.

Policy Writing Activity: Family Day Care Homes (FDC Homes)

Of the 18 companies/groups reporting data for FDC Homes in 2010, 6 insurers had direct written premium exceeding \$100,000. These 6 insurers provided coverage for 11,869 FDC Home providers, approximately 97.3% of all the FDC business insured. Of these 18 insurers: 7 carriers insured from 0 to 10 providers each; 4 carriers insured between 11 and 100 providers each; 1 carrier insured between 101 to 450 providers; and 6 carriers insured over 450 providers each.

Of the 18 insurers that wrote child care liability insurance for FDC Homes in 2010, 16 insurers wrote coverage for Small FDC Homes (licensed for 1 to 6 children) and 10 wrote coverage for Large FDC Homes (licensed for 7 to 12 children). Of the 16 Small FDC Home insurers, 4 insurers had direct written premium exceeding \$100,000. They insured approximately 94.6% of all Small FDC Homes. Of the 10 Large FDC Home insurers, 3 insurers had direct written premium exceeding \$100,000. They insured 97.6% of all Large FDC Homes.

Policy Writing Activity: Child Care Centers (CC Centers)

Of the 23 companies/groups which submitted data for licensed Child Care Centers in 2010, 10 insurers had direct written premium exceeding \$100,000. These 10 carriers insured approximately 97.2% of the CC Center business.

Of the 23 insurers submitting data: 7 carriers insured from 0 to 10 CC Centers each; 5 carriers insured between 11 and 50 CC Centers; 2 carriers insured between 51 and 200 CC Centers; and 9 insurers wrote more than 200 CC Centers in 2010.

INSURERS' ACTIVITY IN 2010

The information provided for calendar year 2010 shows that there was a decrease in the number of FDC Homes providers insured. In particular, a number of policies for Large

FDC Homes were non-renewed. The total loss ratio for Large FDC Homes was 110.53%, with a combined ratio of 168.61%. The number of insured CC Centers increased. The majority of the coverage being written in California is still being provided by a handful of insurers, particularly with regards to FDC Homes. The following exhibits were developed from the data provided by the insurers.

EXHIBIT I: Comparison of Insurers' Participation in the Child Care Liability Insurance Market

	Family Day Care Homes		Child Care Centers	
	Calendar Year 2009	Calendar Year 2010	Calendar Year 2009	Calendar Year 2010
# of Insurers Reporting Data	17	18	20	23
# of Policies In-Force at Beginning of Year	11,967	11,836	3,744	4,014
# of Policies In-Force at End of Year	11,795	9,990	3,125	3,933
Change in # of Policies In-Force at End of Year	-1.44%	-15.60%	-16.53%	-2.02%
# of Insurers w/ No Policies In-Force at End of Year	0	2	1	2

**EXHIBIT II: Insurers Reporting Child Care Data for Calendar Year 2009 vs. 2010
per CIC §1864**

INSURERS REPORTING:	CALENDAR YEAR 2009		CALENDAR YEAR 2010		Policy Type
	Family DC Homes	Child Care Centers	Family DC Homes	Child Care Centers	
ACE USA		X		X	OC
Allstate Insurance Group	X		X		OC
American Alternative Insurance Corp				X	CL/OC
Armed Forces Insurance Exchange	X		X		OC
Brotherhood Mutual Insurance Co.		X		X	OC
California Casualty Insurance Cos.	X		X		OC
Church Mutual Insurance Co.	X	X	X	X	OC
Diamond State Insurance Co.		X	X	X	CL
Farmers Insurance Group	X		X	X	CL/OC
Grange Insurance Group	X		X		OC
Great American Insurance Group		X		X	OC
GuideOne Insurance Group	X	X	X	X	OC
Hartford (The)	X	X	X	X	OC
Markel Insurance Co.	X	X	X	X	OC
Mitsui Sumitomo Ins. Co. of America		X		X	OC
Mitsui Sumitomo Insurance USA Inc.		X		X	OC
Pacific Property & Casualty Co.	X		X		OC
Penn-America Ins. Co.	X	X	X	X	OC
Philadelphia Indemnity Insurance		X		X	OC
Riverport Insurance Co. of CA	X	X	X	X	OC
SAFECO Insurance Companies	X	X	X	X	CL
SPARTA Insurance Company		X		X	OC
State Farm Insurance Cos.	X	X	X	X	OC
Travelers Insurance Cos.		X		X	OC
Stonington Insurance Co.	X	X	X	X	OC
TOPA Insurance Company	X	X	X	X	OC
Unigard Insurance Group	X		X		OC
Wesco Insurance Company				X	OC
Zurich U.S. Ins. Group		X		X	OC
# of Insurers Submitting Data	17	20	18	23	

Total # of Insurers Submitting Data for 2009: 27

Total # of Insurers Submitting Data for 2010: 29

EXHIBIT III: CALIFORNIA CHILD CARE PROVIDERS LIABILITY INSURANCE REPORT (CIC Sec. 1864) LICENSED FAMILY DAY CARE HOMES & CHILD CARE CENTERS

	FAMILY DAY CARE HOMES Licensed for 1-6 or 7-12 Children		CHILD CARE CENTERS Licensed: 13 or more Children		COMBINED DATA FDC Homes & CC Centers	
	CALENDAR YEAR 2009	CALENDAR YEAR 2010	CALENDAR YEAR 2009	CALENDAR YEAR 2010	CALENDAR YEAR 2009	CALENDAR YEAR 2010
# Insurers Reporting Data	17	18	20	23	27	29
1) Premiums Earned	\$2,726,934	\$2,656,974	\$4,320,128	\$4,729,609	\$7,047,061	\$7,386,583
2) Premiums Written	\$3,803,803	\$3,707,514	\$4,999,361	\$5,707,863	\$8,803,164	\$9,415,377
3) Total Losses Incurred	(\$128,122)	\$1,956,440	\$4,669,350	\$3,765,151	\$4,541,228	\$5,721,591
4) Loss Ratio (3)/(1)	-4.70%	73.63%	108.08%	79.61%	64.44%	77.46%

Number of Policies:

	FAMILY DAY CARE HOMES Licensed for 1-6 or 7-12 Children		CHILD CARE CENTERS Licensed: 13 or more Children		COMBINED DATA FDC Homes & CC Centers	
	CALENDAR YEAR 2009	CALENDAR YEAR 2010	CALENDAR YEAR 2009	CALENDAR YEAR 2010	CALENDAR YEAR 2009	CALENDAR YEAR 2010
In-Force at Beginning of Year	11,967	11,836	3,744	4,014	15,711	15,850
Written During the Year	3,792	3,238	514	577	4,306	3,815
Cancelled During the Year	871	743	395	440	1,266	1,183
NonRenewed During the Year	3,093	4,341	738	218	3,831	4,559
In-Force at End of Year	11,795	9,990	3,125	3,933	14,920	13,923

**EXHIBIT IV: CALIFORNIA CHILD CARE PROVIDERS LIABILITY INSURANCE REPORT
(CIC Sec. 1864) DATA REPORTED FOR LICENSED FAMILY DAY CARE HOMES**

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR 2009	CALENDAR YEAR 2010	CALENDAR YEAR 2009	CALENDAR YEAR 2010
# OF INSURERS REPORTING FDC INFO.	16	16	9	10
1) Premiums Earned	\$1,452,539	\$1,414,849	\$1,274,395	\$1,242,125
2) Premiums Written	\$1,733,412	\$1,678,016	\$2,070,391	\$2,029,498
3) Total Losses Incurred	\$621,140	\$583,554	(\$749,262)	\$1,372,886
4) Loss Ratio (3)/(1)	42.76%	41.24%	-58.79%	110.53%

**EXHIBIT IV: CALIFORNIA CHILD CARE PROVIDERS LIABILITY INSURANCE REPORT
(CIC Sec. 1864) DATA REPORTED FOR LICENSED FAMILY DAY CARE HOMES
(continued)**

Number of Policies:

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR 2009	CALENDAR YEAR 2010	CALENDAR YEAR 2009	CALENDAR YEAR 2010
In-Force at Beginning of Year	8,454	8,183	3,513	3,653
Written During the Year	3,238	2,900	554	338
Cancelled During the Year	634	583	237	160
NonRenewed During the Year	2,911	2,603	182	1,738
In-Force at End of Year	8,147	7,897	3,648	2,093

Average Written Premium per Policy

The premium per policy that an insurer charges for a child care liability insurance policy or a homeowners' endorsement are not required to be filed under this section of the Insurance Code. Subsequently, we are able to calculate only a rough estimate of the average written premium (AWP) per policy written based on the information submitted.

Exhibit VI summarizes the AWP for a FDC Home (Small and Large) policy and for a CC Center policy, based on available data from 2000 to 2010. The AWPs were calculated after removing the direct written premium for insurers that could not provide a policy written count.

EXHIBIT V: ESTIMATED AVERAGE WRITTEN PREMIUM**Family Day Care (FDC) Homes & Child Care Centers**

Year	Small FDC Homes	Large FDC Homes	Small + Large FDC Homes	Child Care Centers
2000 *	\$212.11	\$490.75	\$298.47	\$2,775.13
2001 *	\$227.75	\$764.92	\$242.08	\$2,093.76
2002	\$319.16	\$1,054.67	\$521.95	\$3,036.13
2003	\$318.57	\$1,034.42	\$554.94	\$4,297.50
2004	\$323.29	\$1,025.98	\$585.15	\$5,624.15
2005	\$310.17	\$631.74	\$425.51	\$3,839.75
2006 **	\$497.34	\$2,934.89	\$975.57	\$6,029.30
2007	\$559.22	\$3,531.46	\$1,044.72	\$9,103.33
2008	\$497.50	\$3,908.65	\$935.50	\$9,734.13
2009	\$535.33	\$3,737.17	\$1,003.11	\$6,583.12
2010	\$578.63	\$6,004.43	\$1,145.00	\$6,863.23

* Missing 1 insurer's data in 2001 - possibly 2000 also.

** 2006: # of Policies Written revised by 1 company.

Note for Child Care Centers:

2000: AWP was calculated based on data from 26 of 27 insurers with DWP of \$4,104,022 and policies written of 1,479.

2001: AWP was calculated based on data from 24 of 25 insurers with DWP of \$4,380,155 and policies written of 2,092.

2002: AWP was calculated based on data from 19 of 20 insurers with DWP of \$5,319,299 and policies written of 1,752.

2003: AWP was calculated based on data from 16 of 18 insurers with DWP of \$6,270,046 and policies written of 1,459.

2004: AWP was calculated based on data from 16 of 20 insurers with DWP of \$5,494,796 and policies written of 977.

2005: AWP was calculated based on data from 18 of 19 insurers with DWP of \$5,621,390 and policies written of 1,464.

2006 **: AWP was calculated based on data from 13 of 17 insurers with DWP of \$5,739,895 and policies written of 952.

2007: AWP was calculated based on data from 12 of 16 insurers with DWP of \$5,671,372 and policies written of 623.

2008: AWP was calculated based on data from 16 of 18 insurers with DWP of \$5,577,658 and policies written of 573.

2009: AWP was calculated based on data from 15 of 20 insurers with DWP of \$4,983,419 and policies written of 757.

2010: AWP was calculated based on data from 18 of 23 insurers with DWP of \$5,655,305 and policies written of 824.

2011 ANNUAL REPORT
ENFORCEMENT BRANCH

ENFORCEMENT BRANCH

INSURANCE CODE SECTIONS 1872.9, 1872.96, 1874.8

Pursuant to Sections 1872.9, 1872.96 and 1874.8 of the California Insurance Code and consistent with reporting protocols of the California Department of Insurance, the Enforcement Branch provides information relating to the specific duties of each of its divisions, program oversight and expenditures and specific activities for Fiscal Year 2010-11.

Section One: Enforcement Branch Overview

Section Two: Investigation Division

Section Three: Fraud Division

Section Four: Workers' Compensation Insurance Fraud Program

Section Five: Appendices

SECTION ONE: BRANCH OVERVIEW

The Enforcement Branch is composed of two divisions: Fraud and Investigation. The Branch investigates criminal and regulatory violations starting with point-of-sale transactions through the claims process.

BRANCH MISSION STATEMENT

“To protect the public from economic loss and distress by actively investigating, arresting, and referring, for prosecution or other adjudication, those who commit insurance fraud and other violations of law; to reduce the overall incidence of insurance fraud and consumer abuse through anti-fraud outreach and training to the public, private, and governmental sectors.”

BRANCH ORGANIZATION

Branch Management – The Enforcement Branch Management consists of the Deputy Commissioner, two Division Chiefs, (Investigation and Fraud Divisions), two Bureau Chiefs (Fraud Division), a Captain, (Supervising Fraud Investigator II), one Headquarters Chief, (Staff Services Manager II), and an Executive Assistant.

Branch Headquarters – The Headquarters Chief is responsible for the management of the Branch Headquarters Office that supports the Enforcement Branch Deputy Commissioner and the Fraud and Investigation Divisions’ regional offices. This position works closely with other units within the Department, most notably Human Resources Management Division, Budget and Revenue Management Bureau, Accounting Services Bureau, Information Technology Division, and Business Management Bureau. The Headquarters Chief reports to the Deputy Commissioner.

Enforcement Branch Headquarters consists of six units performing the following activities in support of Enforcement Branch Regional Offices.

1. Human Resources and Training
2. Local Assistance
3. Management Reporting and Intake
4. Fraud Grant Audit Unit
5. Special Investigative Unit – Compliance Review Office
6. Budgets, Property Control and Special Projects

Fraud Grant Audit Unit – The primary responsibility of the Fraud Grant Audit Unit (FGAU) is to conduct fiscal audits of the Workers’ Compensation, Automobile, Organized Automobile Fraud Activity Interdiction, Disability and Healthcare, and Life and Annuity Consumer Protection Program insurance fraud grants awarded to participating California district attorney’s offices. The purpose of the audit is to provide reasonable assurance that the funds have been used for enhanced investigation and prosecution of specific types of insurance fraud in accordance with applicable statutes and regulations. If a district attorney’s office participates in more than one insurance fraud program, the programs are audited concurrently to maximize efficiency. The audit findings may impact future grant funding.

California Insurance Code Sections 1872.8(b)(1)(D) and 1874.8(d) require the California Department of Insurance (CDI) to conduct fiscal audits of the Automobile and Organized Automobile Insurance Fraud Grant Programs at least once every three years. California Code of Regulations Sections 2698.67(h), 2698.77(e)(1) and 2698.98.1(h) require the CDI to conduct fiscal audits of the Automobile, Organized Automobile Fraud Activity Interdiction, and Disability and Healthcare Fraud Grant Programs once every three years. California Code of Regulations Section 2698.59(f) and California Insurance Code Section 10127.17 authorize the CDI to conduct fiscal audits of the Workers' Compensation Insurance Fraud Program and the Life and Annuity Consumer Protection Program.

In Fiscal Year 2010-11, the FGAU completed fiscal audits of 14 district attorneys' offices; a total of 80 grants were audited.

Workers' Compensation	35
Automobile	30
Organized Automobile	6
Disability and Healthcare	3
Life and Annuity	6

The most common findings are indicated below:

- Financial audit report by an independent auditor was not submitted timely
- Expenditure report was not submitted or not submitted timely

After the FGAU completes its analysis, a preliminary report is issued to the district attorney's office; there are 30 days to respond and provide additional information for consideration. A final report is issued to the district attorney, CDI Enforcement Branch Deputy Commissioner, Division Chiefs, Bureau Chiefs, Regional Office Captains, Enforcement Branch Headquarters Chief, Program Managers, and the Legal Division, as appropriate.

Professional Standards Unit/Backgrounds – The Captain coordinates all internal affairs investigations and supervises a team of retired annuitants who perform all pre-employment background investigations for the Branch. This position conducts special projects when needed. The Professional Standards Unit/Backgrounds Captain reports to the Deputy Commissioner.

Professional Standards Unit/Computer Forensic Team (CFT) – A Detective Sergeant (Supervising Fraud Investigator I) coordinates the tasks of the Computer Forensic Team that supports statewide investigative efforts through technical expert forensic examinations of computer data seized during investigations. The CFT Detective Sergeant reports to the Professional Standards Unit/Backgrounds Captain.

Professional Standards Unit/Enforcement Tactics and Training Unit (ETTU) – A Detective Sergeant (Supervising Fraud Investigator I), coordinates the tasks of training, weapons management, and range masters in the Enforcement Tactics and Training

Unit to all sworn staff. The ETTU Detective Sergeant reports to the Professional Standards Unit/Backgrounds Captain.

ANTI-FRAUD OUTREACH

One component of the Enforcement Branch's mission statement is to provide anti-fraud outreach and training to the public, private and governmental sectors. The Branch provides a wide array of public awareness through liaisons and materials. The following are examples of the outreach activities:

Internet

The CDI Internet public website includes but is not limited to the following subjects: What is Insurance Fraud; Insurance Fraud Reporting Forms; Where to Report Insurance Fraud; Fraud Division Regional Offices; Workers' Compensation Insurance Fraud Convictions; and Press Releases.

Posting Convictions on Website – Consistent with the requirements of California Insurance Code Section 1871.9, the Department posts fraud convictions on its website for five years from the date of conviction or until it is notified in writing that the conviction has been reversed or expunged.

Community Forums

The Enforcement Branch participates in community-sponsored events, such as town hall meetings, public hearings, and underground economy seminars. These forums give the Branch opportunities to hear directly from consumers regarding their insurance concerns, and provide information communities can use to protect themselves from insurance fraud.

Media/Public Service Announcements

The Enforcement Branch participates with local, state, and national broadcasting outlets to educate the public about insurance fraud in California. The Branch's accomplishments are highlighted so the public is aware of workers' compensation arrests, prosecutions, and convictions throughout the State. With this in mind, significant cases are taken to the media, in partnership with other law enforcement agencies, to educate the public about the Division's activities and promote deterrence.

Industry Liaison

The Enforcement Branch maintains ongoing liaison with the insurance industry by interacting with a variety of organizations, including the International Association of Special Investigation Units; Workers' Compensation Advisory Committee; Insurance Fraud Advisory Board; National Insurance Crime Bureau Regional Advisory Committee; Health Fraud Task Force; Underground Economy Task Forces; California Coalition on Workers' Compensation; California Workers' Compensation Institute; Northern California Fraud Investigators Association; and the Southern California Fraud Investigators Association.

Governmental Liaison

The Enforcement Branch maintains a routine and specific liaison with the following State agencies or entities on matters of overlapping jurisdiction or mutual concern: California Peace Officers' Association; California Peace Officers Standards and Training; Instructor Standards Counsel; California Highway Patrol; Employment Development Department; Department of Industrial Relations—Division of Workers' Compensation and Division of Labor Standards Enforcement; Department of Consumer Affairs, Bureau of Automotive Repair, California Contractors State License Board, and the Cemetery and Funeral Bureau; Department of Justice; Department of Corporations; Franchise Tax Board; California Board of Chiropractic Examiners; California District Attorneys Association; National Association of Insurance Commissioners; Statewide Vehicle Task Force; Advisory Committee on Automobile Insurance Fraud; Department of Corrections and Rehabilitation; Department of Alcoholic Beverage Control; and Regional Auto Theft Task Forces.

Grant Workshops for County District Attorney's Offices

The Local Assistance Unit, Fraud Grant Audit Unit, and regional offices of the Fraud Division jointly held training workshops for district attorney personnel who participate in the Insurance Fraud Grant Programs. The workshop was specifically designed for staff responsible for complying with the data collection and reporting requirements associated with the programs. The workshop covered the administration of the grant programs, audit of grant programs, the components of a successful joint plan, and a discussion regarding the procedures to deal with fraud complaints and referrals that are received by both the Fraud Division and the district attorney. The workshops have been given statewide.

Public Awareness

The Department's goal is through public awareness to advance communications to help consumers understand insurance fraud and to create stronger deterrence.

SECTION TWO: INVESTIGATION DIVISION

The Investigation Division is charged with enforcing applicable provisions of the California Insurance Code under authority granted by Section 12921 and to certify crimes of which the Commissioner has knowledge to a prosecuting authority pursuant to Insurance Code Sections 12928 and 12930. The Investigation Division pursues prosecutions of offenders through both regulatory and criminal justice systems.

The mission of the Investigation Division is to protect California consumers by investigating suspected violations of laws and regulations pertaining to the business of insurance and seeking appropriate enforcement actions against violators. Effective enforcement of the insurance laws helps to safeguard consumers and insurers from economic loss and eliminate unethical conduct and criminal abuse in the insurance industry.

The Insurance Commissioner established case priorities for the Investigation Division to include premium theft, senior citizen abuse, unauthorized insurers, deceptive sales and marketing practices, title insurance rebates, public adjuster violations, abusive acts committed by auto insurance agents and companies and illegal bail practices.

BUDGET AND STAFFING

During the Fiscal Year 2010 -11, the Investigation Division's expenditures totaled \$8,023,781.10 in support of an authorized staff of 92 positions.

INVESTIGATION DIVISION (ADMINISTRATION AND OPERATIONS)

Division Chief – Under the general direction of the Deputy Commissioner, the Division Chief oversees a statewide consumer protection and law enforcement unit consisting of regional offices and administrative staff.

Branch Headquarters – The Enforcement Branch Headquarters is responsible for administering statewide programs such as the Life and Annuity Consumer Protection Program and to provide administrative services to the Investigation Division regional chief investigators and their staff.

Division Case Intake and Inquiry Unit – As part of the Branch Headquarters, this unit receives and reviews information from the public, governmental agencies, the insurance industry, law enforcement, and other units within the Department. All reports of suspected violations are entered into the Investigation Division database for tracking and intelligence purposes. Reports of suspected violations are assigned to regional offices to conduct the investigation. The unit further processes all Division inquiries and requests from consumers, other CDI branches and from other governmental agencies.

Investigation Division Regional Offices – There are seven regional offices located throughout California. Each regional office is managed by a Chief Investigator and consists of first-line supervisors, investigators, and support staff. Each regional office is responsible for investigating reports of suspected violations under their jurisdictional territories.

Criminal Operations Point of Sale Unit (COPS) – Investigation Division Investigators are empowered by Penal Code § 830.11 to exercise the powers of arrest and to serve warrants during the course and scope of their employment. Additionally, the Department established the Criminal Operations Point of Sale Unit (COPS), a team of investigators within the Division, including sworn peace officers. COPS' primary objective is to protect the public by conducting efficient and effective criminal investigations, effect arrests, execute search warrants, serve as liaison with allied law enforcement and advance the Department's continuing goal of protecting consumers using its full peace officers powers as set forth in Penal Code 830.3.

Investigation Division Violations: The following categories identify the types of violations investigated by the Division:

1. **Premium Theft** - The theft of insurance premiums is the single most prevalent type of misconduct seen in the insurer producer area. Instances can range from a single theft to multi-million dollar scams causing the insurance industry and competitive businesses to become the unwitting victims of financial loss.
2. **Senior Citizen Abuse** - Certain segments of the insurance industry target their marketing efforts toward senior citizens. Some agents and insurers abuse elderly customers by churning and twisting existing policies or by selling them new, unsuitable insurance products. At times, the misconduct is criminal, involving theft, false documents, Ponzi schemes and confidence games.
3. **Deceptive Sales and Marketing Practices** - The failure of some insurers to properly monitor and control their sales force can lead to unethical and misleading marketing practices such as bait and switch schemes, misrepresentation and the use of misleading titles and designations.
4. **Unauthorized Insurance Companies** - This type of fraud includes everything from phony insurance cards sold in DMV parking lots to fully-operational offshore insurance companies issuing policies they have no intention of honoring.
5. **Public Adjuster Misconduct** - Public adjusters represent insurance claimants in the settlement of claims with their insurance companies. Misconduct in this area includes high-pressure sales, overcharging, conflicts of interest with vendors, and failure to account for claims proceeds.
6. **Title Company Rebates and Kick-Backs** - Kickbacks and commercial bribery are among the anti-competitive practices used to gain business from realtors.
7. **Bail Agent Activity** - A bail agent is a person permitted to solicit, negotiate, and transact undertakings of bail on behalf of a surety insurer. Some

unscrupulous bail agents fail to return collateral, aid and abet unlicensed bail agents or apprehend arrestees with the intent to extort premium payments.

In addition to these types of violations, the Division investigates other complaints and alleged violations of laws relating to the transaction of insurance by individuals and entities conducting business within the State as provided in the California Insurance Code, California Business and Professions Code, California Code of Regulations, California Penal Code, and Title 18 of the United States Code.

DIVISION WIDE INVESTIGATIONS

Fiscal Year 2010-11

Complaints and General Correspondence Received	1,474
Opened	882
Additional Complaints - Consolidated with Existing Cases.....	247
Completed.....	795

In Progress as of June 30, 2011:

Criminal Cases	541
Regulatory/Administrative Cases	391
Total	932

Reports of Suspected Violation¹ as of June 30, 2011:

Criminal Cases	70
Regulatory/Administrative Cases	199
Total	269

¹ Any initial allegation that is found sufficient to warrant an investigation but which has not yet been assigned to an investigator. It is intended to represent matters that are potential future investigations.

Chargeable Fraud	\$8,658,627
Ordered Restitution	\$18,788,269
Investigative Cost Recoveries	\$88,028
Fines and Penalties.....	\$158,583

CRIMINAL PROSECUTION CASES:

Fiscal Year 2010-11

Referral to Prosecutors	100
Case Filed by Prosecutors	46
Search Warrants Obtained.....	45

Arrest Warrants Obtained.....	30
Arrested.....	33
Convictions.....	31

REGULATORY PROSECUTION CASES:

Fiscal Year 2010-11

Cases referred for regulatory prosecution	134
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INVESTIGATION DIVISION FUNDING

Most investigations conducted by the Investigation Division are compensated by revenues generated from fees and licenses charged to the insurance industry. Two areas of investigations which are specially funded are investigations related to automobile insurance and investigations related to Life and Annuity Consumer Protection Programs.

INVESTIGATIONS RELATED TO AUTOMOBILE INSURANCE

Insurance Code Section 1872.81 requires each insurer doing business in California to pay to the Insurance Commissioner an annual fee of thirty-cents for each insured vehicle it covers in the State. The purpose of the fee is to maintain and improve consumer service functions related to automobile insurance.

AUTO INSURANCE INVESTIGATIONS²

Fiscal Year 2010-11

Opened	147
Completed.....	153
In progress as of June 30, 2011	212
Reports of Suspected Violation as of June 30, 2011.....	37

²This data is included in the overall Division case information shown on the previous sections of this report.

INVESTIGATIONS RELATED TO LIFE INSURANCE AND ANNUITY PRODUCTS

Effective January 1, 2005, Assembly Bill 2316, (Chapter 835, Statutes of 2004), created the Life and Annuity Consumer Protection Fund (CIC §10127.17). Monies from this fund are dedicated to protecting consumers of life insurance and annuity products. Revenue generated pursuant to this program is divided between the Department of Insurance and Local Assistance Grants to various county district attorney offices.

In this fifth year of grant funding, the Life and Annuity Consumer Protection Program provided \$1,248,955 in grant funds to eleven counties. As a result of this collaborative effort, several licensed agents were prosecuted and convicted of theft, financial elder

abuse, forgery, and identity theft in the transaction of life insurance and annuities with California consumers.

LIFE INSURANCE AND ANNUITY PRODUCTS INVESTIGATIONS³

Fiscal Year 2010-11

Opened	200
Completed	169
In progress as of June 30, 2011	207
Reports of Suspected Violation as of June 30, 2011	71

³ This data is included in the overall Division case information shown on the previous sections of this report.

LIFE INSURANCE AND ANNUITY CONSUMER PROTECTION PRODUCTS DATA

Assembly Bill 76 (Chapter 75, Statutes of 2009) amended Section 10127.17 of the Insurance Code, relating to life insurance and annuity products. The bill extended the operation of the Life and Annuity Consumer Protection Fund to January 1, 2015. The bill also required the Insurance Commissioner to annually publish a report to include the following information:

Calendar Year 2011

Opened Consumer Complaints	2,221
Opened Investigations.....	175
Investigations referred to/reported by prosecuting agencies	41
Administrative or regulatory cases referred to the Department’s Legal Division	21
Administrative or regulatory enforcement actions taken.....	8

Senior citizens are often the targets of life and annuity financial abuse. The Department participated in approximately 60 senior outreach events, during calendar year 2011, in which staff discussed issues such as purchasing annuities, and scams committed against seniors in purchasing insurance, including life insurance and annuities. Some of the entities with which we participated with are: Lifestyles in Motion in Mission Viejo; Wise & Healthy Aging in Santa Monica; Los Angeles Department of Consumer Affairs in Los Angeles; Contractors State License Board – Senior Scam Stoppers in Riverside, Fontana, Laguna Woods, Corona and Norwalk; California Public Utilities Commission in Calimesa and San Bernardino; Senior Citizen Centers in El Monte, San Luis Obispo, Orange County and Santa Clara; Smarter Senior Forums in Los Angeles, Pasadena, Camarillo and San Joaquin; and Senior Health Fairs in Bakersfield, Los Angeles and El Dorado.

The Department distributes information brochures concerning insurance topics to the public during outreach events. During 2011, the following brochures relating to seniors were distributed:

- *What Seniors Need to Know About Annuities* – 1,827 copies
- *Senior Insurance Bill of Rights* – 2,265 copies
- *Informing Seniors – Tips for Dealing with Insurance* – 575 copies

The Department also assists insurance consumers with complaints relating to Life and Annuity issues. The CDI has developed and conducted an advertising campaign called *Senior Advisory*, which is placed with various magazine publications throughout the State. The publications used during 2011 were: Grace Communications, Southland Publishing, Capital City Media, Today's Senior Magazine, Golden Rain Foundation, Southern California Resources, California Association on Area Aging, and AARP.

INITIATIVES TO REDUCE PRODUCER FRAUD:

In order to reduce incidents involving producer fraud, the Investigation Division has implemented the following:

1. Established quality control measures at the regional level to ensure compliance of Division policies designed to improve efficiency and increase productivity.
2. Established the Investigation Division Disaster Assistance Response Team (DART) to work in conjunction with other CDI divisions and allied agencies to proactively respond to disasters or other emergencies statewide affecting enforcement operations.
3. In conjunction with CDI's Legal Enforcement Bureau, developed the Visiting Attorney Program (VAP) to assist in the review of on-going casework, as well as reports of suspected violations, to ensure that the Division is achieving an efficient use of its resources.
4. Improved Investigation Division Database to better identify suspects of investigations, economic impact information and patterns of non-compliance by individuals and entities involved in the transaction of insurance.
5. Provided Life and Annuity Consumer Protection Program (LACPP) training to county prosecutors, local law enforcement agencies and consumer groups
6. Ongoing development of legislative proposals to strengthen laws governing the transaction of insurance and the enforcement of those laws.
7. Ongoing outreach to industry associations, consumer groups and allied law enforcement agencies.

**California Department of Insurance
Enforcement Branch Headquarters**

9342 Tech Center Drive, Suite 100
Sacramento, CA 95826
Phone: (916) 854-5760

Investigation Division Regional Offices

Office	Location	Counties Served
Benicia	1100 Rose Drive, Suite 100 Benicia, CA 94510 Phone: (707) 751-2000	Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, and Solano
Inland Empire	9674 Archibald Ave., Suite 100 Rancho Cucamonga, CA 91730 Phone: (909) 919-2200	Inyo, Riverside and San Bernardino
Los Angeles	300 South Spring St., 10th Floor Los Angeles, CA 90013 Phone: (213) 346-6006	Central and Southern Los Angeles County
Orange	333 S. Anita Drive, Suite 450 Orange, CA 92868 Phone: (714) 712-7600	Orange
Sacramento	9342 Tech Center Drive, Suite 500 Sacramento, CA 95826 Phone: (916) 854-5700	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba
San Diego	10021 Willow Creek Rd., Suite 100 San Diego, CA 92131 Phone: (858) 693-7100	Imperial and San Diego
Valencia	27200 Tourney Road, Suite 375 Valencia, CA 91355 Phone: (661) 253-7500	Fresno, Kern, Kings, Madera, Mariposa, Merced, Northern Los Angeles, San Luis Obispo, Santa Barbara, Tulare, and Ventura

SECTION THREE: FRAUD DIVISION

The CDI's Fraud Division has the responsibility of ensuring the provisions outlined in Chapter 12 of the California Insurance Code, "The Insurance Frauds Prevention Act" and Penal Code Section 550 are enforced throughout the State of California.

The mission of the Fraud Division is "to protect the public and prevent economic loss through the detection, investigation, and arrest of insurance fraud offenders."

BUDGET AND STAFFING

Fiscal Year 2010-11 Fraud Division Budgeted/Revenue/Expenditures by Program and Fiscal Year Staffing level:

Fraud Auto Revenues⁴ \$37,585,000

Insurance Fraud Assessment, Auto

Budgeted Levels: \$40,708,000

District Attorneys' Auto Distribution: \$21,845,000

State Operations Auto Expenditures: \$17,153,000

Insurance Fraud Assessment, Workers' Compensation

Budgeted Levels: \$47,398,000

District Attorneys' Workers' Compensation Distribution: \$29,901,000

State Operations Workers' Compensation Expenditures: \$16,681,000

Insurance Fraud Assessment, Disability and Healthcare

Budgeted Levels: \$3,321,000

District Attorneys' Disability and Healthcare Distribution: \$1,712,000

State Operations Disability and Healthcare Expenditures: \$1,764,000

Insurance Fraud Assessment, General

Budgeted Levels: \$2,077,000

State Operations General Assessment Expenditures: \$2,645,000

Fiscal Year 2010-11 Fraud Division Positions⁵ 289

FRAUD DIVISION (ADMINISTRATION AND OPERATIONS)

The Fraud Division has nine regional offices serving all 58 counties. The Enforcement Branch Headquarters office administratively supports all Fraud Division regional office operations, including those activities related to the management of the statewide grant programs, as well as centralized support of investigations in the Automobile, Organized Automobile Fraud Interdiction Program, Workers' Compensation, Disability and Healthcare, and Property and Casualty Fraud Programs.

⁴ Auto revenues exclude the \$0.30 assessment per SB 940 which is not used for Fraud Division programs.

⁵ Includes all authorized program 20 positions.

Division Chief – Under the general direction of the Enforcement Branch Deputy Commissioner, and working closely with the Southern and Northern Fraud Division Bureau Chiefs, the Division Chief plans, organizes, and evaluates operations of the Fraud Division, including the investigations of illegal activities, and coordinates activities with various federal and state government entities in the prosecution of violators.

The Division Chief evaluates district attorney's offices receiving program grants, reviews Request for Applications (RFA) made by district attorneys; makes recommendations to the Insurance Commissioner and Deputy Commissioner regarding RFAs, Fraud Division policy, procedures, issues, and regulations, and new anti-fraud legislation and regulations.

Bureau Chiefs - Under the general direction of the Fraud Division Chief, Bureau Chiefs generally carry-out, and coordinate the work of multiple offices engaged in the investigation of violations of insurance and related penal statutes.

The Bureau Chief responsible for the northern region oversees the Sacramento, Benicia, Silicon Valley, and Fresno regional offices and has program oversight responsibility for the Workers' Compensation and Disability and Healthcare Fraud Programs.

The Bureau Chief responsible for the southern region oversees the Inland Empire, Orange, Valencia, Southern Los Angeles County and San Diego regional offices and has program oversight responsibility for Fraud Division's two Automobile Fraud Programs – (Regular) Automobile Insurance Fraud and Organized Automobile Fraud Activity Interdiction – and the Property and Casualty Fraud Program.

AUTOMOBILE INSURANCE FRAUD PROGRAM

The Fraud Division is the primary law enforcement agency responsible for investigating automobile insurance fraud crimes. The Fraud Division coordinates enforcement operations statewide with municipal, state and federal enforcement agencies. Completed investigations are filed with the local district attorney or the United States Attorney General's Office.

Fraud Division detectives primarily enforce the provisions of California Penal Code Sections 548 – 550. Detectives focus on five major categories: medical mills, organized crime, staged collision rings, false and fraudulent claims, and organized economic automobile theft groups. Organized criminal elements have and continue to use these types of schemes.

Fiscal Year 2010-11, the Fraud Division received 16,927 suspected fraudulent claims (SFCs), assigned 621 new cases, and made 227 arrests and referred 262 submissions to prosecuting authorities. The potential loss amounted to \$149,224,681.

District Attorneys' Automobile Insurance Fraud Program

During Fiscal Year 2010-11, 33 counties received funding totaling \$15,259,000 through the Department's Auto Insurance Grant Program. The amount of financial support

funded to each county is derived from three components: county population, the number of SFCs reported, and a plan to utilize the grant funding.

For Fiscal Year 2010-11, the district attorneys initiated 2,509 investigations and made 1,241 arrests, culminating in 908 convictions, which includes the Fraud Division's enforcement actions, and local law enforcement investigations.

Chargeable fraud amounted to \$13,994,342, with \$2,797,076 in restitution ordered by the courts.

ORGANIZED AUTOMOBILE FRAUD ACTIVITY INTERDICTION

The California State Legislature finds that organized automobile fraud activity operating in the major urban centers of the State represents a significant portion of all individual fraud-related automobile insurance cases. These cases result in artificially higher insurance premiums for core urban areas and low-income areas of the State than for other areas of California. Only a focused, coordinated effort by all appropriate agencies and organizations can effectively deal with this problem.

Assembly Bill 1050, chaptered October 10, 1999, created the Organized Automobile Fraud Activity Interdiction ("Urban Grant") Program in Fiscal Year 2000-01. The California Insurance Code Section 1874.8 mandates the Insurance Commissioner award three to ten grants for a coordinated program targeted at the successful prosecution and elimination of organized automobile fraud activity. The primary focus of the program is directed at the organized criminal activity that occurs in urban areas and which often involves the staging of automobile accidents and the filing of fraudulent automobile accident or damage claims.

Traditionally, legal and medical professionals or their associates mastermind these cases. In recent years, highly sophisticated groups have captured the attention of the Fraud Division, prosecutors and allied law enforcement.

During Fiscal Year 2010-11, the Fraud Division assigned 181 new cases and made 277 arrests and 239 referrals to prosecuting authorities. Potential loss amounted to \$3,647,929.

District Attorneys' Organized Automobile Fraud Activity Interdiction Program

During Fiscal Year 2010-11, ten counties were awarded grant funding totaling \$6,586,044. The grant-awarded to district attorneys reported 249 arrests, which included many of the Fraud Division arrests. District attorneys prosecuted 252 cases involving 551 defendants with chargeable fraud totaling \$8,895,149. District attorney prosecution outcomes totaled 263 convictions.

DISABILITY AND HEALTHCARE FRAUD PROGRAM

According to Section 1871(h) of the California Insurance Code, health insurance fraud is a particular problem for health insurance policyholders. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily.

As mandated by California Insurance Code Section 1872.85(a), funding for the Disability and Healthcare Fraud Program is derived from an assessment of 10 cents annually for each insured under an individual or group insurance policy issued in the State. This funding supports criminal investigations statewide by the Fraud Division and prosecution by district attorneys of suspected fraud involving disability and healthcare fraud.

This program area includes Suspected Fraudulent Claims involving: claimant disability other than workers' compensation, dental claims, billing fraud schemes, immunization fraud, unlawful solicitation, durable medical equipment, and posing as another to obtain benefits.

During Fiscal Year 2010-11, the Fraud Division identified and reported 355 SFCs, assigned 32 new cases, and made 15 arrests and 12 referrals to prosecuting authorities. Potential loss amounted to \$13,600,063.

District Attorneys' Disability and Healthcare Program

In Fiscal Year 2010-11, five counties received funding totaling \$1,712,000 through the Department's Disability and Healthcare Insurance Fraud Grant Program. The district attorneys reported 142 investigations, 62 arrests, and 50 convictions, which also included a majority of Fraud Division arrests. Chargeable fraud amounted to \$239,611,229 with \$4,087,726 restitution ordered by the courts.

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

In California, workers' compensation insurance is a no-fault system. Injured employees need not prove an injury was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury. In addition to medical expenses being covered for injured employees, some injured workers are entitled to a portion of their wages lost due to not being able to work. These benefits make fraudulent workers' compensation claims an enticing target for criminals.

Workers' compensation insurance fraud occurs in simple to complex schemes that often require difficult and lengthy investigations. For example, an employee either inflates the extent of his/her injuries, or simply fabricates injuries altogether. At the other end of the spectrum, white-collar criminals, including doctors and lawyers, entice, pay, and conspire with other individuals in cheating the system through fraudulent activity and insurance companies "pick up the tab," passing the cost onto policyholders, taxpayers and the general public.

The Workers' Compensation Fraud Program was established in 1991 through the passage of Senate Bill 1218 (Chapter 116). The law made workers' compensation fraud a felony, required insurers to report suspected fraud, and established a mechanism for funding enforcement and prosecution activities. Senate Bill 1218 also established the Fraud Assessment Commission to determine the level of assessments to fund investigation and prosecution of workers' compensation insurance fraud.

The funding comes from California employers who are legally required to be insured or self-insured. The total aggregate assessment for Fiscal Year 2010-11 is \$50,157,805.

During Fiscal Year 2010-11, the Fraud Division identified and reported 5,741 SFCs, assigned 501 new cases, made 254 arrests and referred 272 submissions to prosecuting authorities. Potential loss amounted to \$276,894,742.

District Attorneys' Workers' Compensation Program

In Fiscal Year 2010-11, the district attorneys reported a total of 797 arrests, which also included the majority of Fraud Division arrests. During the same timeframe, district attorneys prosecuted 1,264 cases with 1,446 suspects, resulting in 666 convictions. Restitution of \$58,365,532 was ordered in connection with these convictions and \$8,484,998 was collected during Fiscal Year 2010-11. The total chargeable fraud was \$248,118,899, representing only a small portion of actual fraud since many fraudulent activities had not been identified or investigated.

PROPERTY, LIFE AND CASUALTY FRAUD PROGRAM

The Property, Life and Casualty Fraud Program handles criminal investigations involving staged commercial/residential burglaries, life insurance fraud (which includes murder for profit cases), fraudulent natural disaster claims (wildfire, flood, earthquake, wind), slip and fall claims, internal embezzlement cases, false food contamination claims, and false marine claims. Criminal investigations in this program area can involve millions of dollars in loss (especially in life insurance fraud cases), multiple claims for the same loss and multiple suspects. Many of these cases have been jointly investigated with local and federal law enforcement agencies and have been prosecuted at the local, state or federal level.

This program accounts approximately for five percent of the Fraud Division's allocated budgetary resources. The funding stream for this program is generated by a \$2,100 assessment for each certificate of authority in California. These funds are non-restrictive and can be used to support all other Fraud Division program areas if needed; however, they are for Fraud Division use only, as there is no local assistance component in this program area.

During Fiscal Year 2010-11, the Fraud Division identified and reported 5,594 SFCs, assigned 92 new cases, made 42 arrests and referred 38 submissions to prosecuting authorities. Potential loss amounted to \$229,682,863.

SPECIAL INVESTIGATIVE UNIT – COMPLIANCE REVIEW OFFICE

The primary responsibility of the Special Investigative Unit (SIU) Compliance Review Office is to inspect insurance companies to ensure regulatory compliance with regard to the establishment, staffing and operation of the insurer's SIU. The Office also is responsible for updating, distributing, reviewing, monitoring and tracking the annual SIU compliance reports filed by over 1,100 insurance companies each year.

The majority of California licensed insurers are required by California Insurance Code Section 1875.20-24 and California Code of Regulations, Title 10, Section 2698.30-.43 to

establish and maintain Special Investigative Units. Regulation also requires each insurance company to submit an annual compliance report to the Fraud Division, SIU Compliance Review Office. The SIU annual reports must provide adequate information and documentation regarding the insurer's anti-fraud operations, policies and procedures, and anti-fraud training. The SIU Compliance Review Office provides the format and instruction for submission of the reports and reviews, monitors and evaluates the completeness and timeliness of the reports filed annually. After completion of a review and evaluation of the insurers' reports filed annually, the SIU Compliance Review Office considers various risk-based criteria for proper selection of insurers for SIU review. The risk-based criteria include, but are not limited to:

- Prior SIU review history, including follow-up of audit findings and implemented recommendations;
- Possible deficiencies or areas of non-compliance identified during examination of annual SIU compliance reports;
- Quantity and quality of suspected insurance fraud (FD-1 and eFD-1) submissions;
- Insurance that is risky and susceptible to fraud, thus negatively impacting consumers, producers and insurers;
- Volume and nature of complaints received for a particular insurance company;
- Market share of the insurance carrier; and/or
- CDI executive directive.

During Fiscal Year 2010-11, the SIU Compliance Review Office audit staff conducted five on-site audits of primary insurance companies which included 20 subsidiary companies, for a total of 25 insurers. Of the 25 companies reviewed, five were authorized to write workers' compensation insurance in California. Two of the five primary companies reviewed were out of state and three were located in California.

SUSPECTED FRAUDULENT CLAIMS REPORTING

The source of leads for investigations initiated by the Fraud Division is the Suspected Fraudulent Claim (SFC), also known as an FD1 or eFD-1. A suspected fraud referral can be as simple as a telephone call from a citizen or as complex as a "documented referral" with supporting evidence submitted by an insurance carrier. SFCs are received by CDI from various sources, including insurance carriers, informants, witnesses, law enforcement agencies, fraud investigators, and the public.

The vast majority of SFCs are generated by the insurance industry. The standards for referring an SFC are codified by a number of statutes within the Insurance Code and range from when the carrier "believes" or has "reason to believe" to "has reason to suspect" that insurance fraud has occurred. Due to the various referral standards and the different interpretations of those standards, SFCs often fail to rise to the level necessary to result in a criminal conviction.

All referrals submitted to the Fraud Division, regardless of the reporting party and supporting evidentiary information, are assigned a case tracking number, and placed in

the Fraud Integrated Database (FIDB). The referrals are then forwarded to supervisors in the regional office with jurisdiction over the allegations. The supervisors use standard criteria when determining case assignments in the various fraud programs, including:

- Public safety
- Consideration of the Insurance Commissioner’s strategic initiatives
- The quality of the evidence presented
- The priority level of the suspected fraud referral
- The availability of investigative resources
- The jurisdiction for prosecution, especially if the district attorney is receiving grant funds
- If the arrest and conviction of suspects would make an impact on the problem within the county and/or State
- Allegations are abuse rather than fraud, insufficient resources, the statute of limitations, discussion with a district attorney regarding facts of the SFC resulted in rejection or referral to another agency

According to Fraud Division data, the quality of SFCs continues to improve each fiscal year. Several reasons for this trend include:

- The extensive efforts to provide training to insurance claim examiners and SIU personnel by the Fraud Division
- The ability of the FD-1 form to be electronically submitted through the internet
- Current SIU regulations help insurance carriers step up their anti-fraud efforts and become more effective in identifying, investigating, and reporting workers' compensation fraud
- The Fraud Division and district attorneys’ aggressive outreach programs

During Fiscal Year 2010-11, Fraud Division received the following number of Suspected Fraudulent Claims (SFCs) by program:

Auto and Urban Auto.....	16,927
Property Casualty ⁶	5,594
Workers’ Compensation	5,741
Health.....	355
Total.....	28,617

⁶ Includes Health and Disability referrals not submitted under the Health program.

THE NUMBER OF CASES REJECTED BY THE FRAUD DIVISION DUE TO INSUFFICIENT EVIDENCE OR OTHER REASONS

SFCs unassigned due to insufficient evidence:.....	13,910
SFCs unassigned due to other reasons:	9,487

THE NUMBER AND TYPES OF CASES PROSECUTED AS A RESULT OF FUNDING RECEIVED UNDER INSURANCE CODE §1872.86

Insurance Code Section 1872.86 assesses funding for use in property/casualty fraud, which can include false and bogus death claims in order to receive life insurance policy payout, murder for profit in order to obtain life insurance benefits, arson, inflated/faked homeowner claims, false boat claims, arson for profit, and so forth.

Caseload (open and newly assigned)	224
Arrests.....	42
Suspect submissions to district attorneys.....	38

An estimate of the economic value of insurance fraud by type of insurance fraud

The following reflects the total amount of fraud reported to the Fraud Division and extracted from the Fraud Integrated Data Base System.

Type of Insurance Fraud	Amount Paid ¹	Suspected Fraudulent Loss ²	Potential Loss ³
Automobile	\$18,819,018	\$61,650,635	\$149,224,681
“Urban Auto”	\$527,091	\$3,995,705	\$3,647,929
Health	\$24,122,477	\$18,370,497	\$13,600,063
Property Casualty	\$183,681,323	\$137,766,088	\$229,682,863
Workers' Compensation	\$93,119,887	\$85,538,434	\$276,894,742
TOTALS	\$320,269,796	\$307,321,359	\$673,050,278

1. Amount paid on claim to date.
2. Amount paid that is suspected as being fraudulently claimed.
3. Amount of loss/exposure if fraud had gone undiscovered.

RECOMMENDATIONS ON WAYS INSURANCE FRAUD MAY BE REDUCED

The goal of the Fraud Division is to produce quality, cost-effective investigations which result in successful enforcement actions. The Fraud Division, in partnership with local district attorneys, selects those cases which will have the most significant impact on the insurance fraud problem in their area of expertise. All open case assignments are coordinated in a joint effort between the Fraud Division and local district attorneys, particularly those receiving grant funding.

Four critical elements have been identified to achieve successful outcomes: an aggressive outreach program, partnership with key stakeholders, effective trend analysis, and a balanced caseload. To that end, the Fraud Division continues to implement performance measures to gauge productivity and efficiency. This is done to measure the overall return on investment and to maximize the impact on insurance

fraud. Successful outcomes that can have a positive impact on insurance fraud have been measured by three methods of enforcement actions:

- **Criminal** - A completed investigation and aggressive prosecution resulting in convictions, restitution, jail/prison, penalties and fines. This type of enforcement produces the best results, including deterrence of further criminal activity.
- **Civil** - The successful disruption and termination of a criminal enterprise or activity, whether it is a single suspect or an organized ring, have been accomplished by civil actions. A single victim, a collective group of individuals or an insurance carrier has followed up with civil actions resulting in termination of the criminal enterprise and stipulating civil fines and restitution. Additionally, the Fraud Division has worked closely with district attorneys involving unfair business practices and related actions.
- **Investigative Inquiry** – Potential fraud activity or abuse have been stopped and deterred by initial contact from the Fraud Division or district attorney’s office. The preliminary investigative steps taken in these cases often halt or deter activity that does not rise to the level of a full criminal investigation.

BASIC CLAIMS INFORMATION, INCLUDING TRENDS OF PAYMENTS BY TYPE OF CLAIM AND OTHER CLAIM INFORMATION THAT IS GENERALLY PROVIDED IN A CLOSED CLAIM STUDY

Although basic claims information and closed claim studies are not available, the Fraud Division collaborates with the National Insurance Crime Bureau (NICB) on emerging issues and trends in the investigation of insurance fraud crimes. A critical component of this partnership is that Fraud Division has access to the NICB database as well as the Insurance Service Organization database, which has been used for trend analysis. The Fraud Division continues to explore other sources of information that will enhance its ability to identify emerging trends in all programs.

A SUMMARY OF THE FRAUD DIVISION’S ACTIVITIES WITH RESPECT TO THE TOTAL AMOUNT OF COURT- ORDERED RESTITUTION AND THE AMOUNT OF RESTITUTION COLLECTED, PURSUANT TO INSURANCE CODE §1872.86(b)(7)

Fraud Area	Restitution Ordered	Restitution Collected
Automobile	\$2,797,076	\$519,330
“Urban Auto”	\$1,714,608	\$696,837
Health	\$4,087,726	\$1,530,777
Workers' Compensation	\$58,365,532	\$8,484,998

**California Department of Insurance
Enforcement Branch Headquarters**

9342 Tech Center Drive, Suite 100
Sacramento, CA 95826
Phone: (916) 854-5760

Fraud Division Regional Offices

Office	Address	Counties Served
Benicia	1100 Rose Drive, Suite 100 Benicia, CA 94510 (707) 751-2000	Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Solano, and Sonoma
Fresno	1780 East Bullard, Suite 101 Fresno, CA 93710 (559) 440-5900	Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, San Luis Obispo and Tulare
Inland Empire	9674 Archibald Ave., Suite 100 Rancho Cucamonga, CA 91730 Phone: (909) 919-2200	Riverside and San Bernardino
Orange	333 South Anita Drive, Suite 450 Orange, CA 92868 Phone: (714) 712-7600	Orange
Sacramento	9342 Tech Center Drive, Suite 500 Sacramento, CA 95826 Phone: (916) 854-5700	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo and Yuba
San Diego	10021 Willow Creek Rd., Suite 100 San Diego, CA 92131 Phone: (858) 693-7100	Imperial and San Diego
Silicon Valley	18425 Technology Drive Morgan Hill, CA 95037 Phone: (408) 201-8800	Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz
Southern Los Angeles County	5999 E. Slauson Avenue City of Commerce, CA 90040 Phone: (323) 278-5000	Southern Los Angeles County
Valencia	27200 Tourney Road, Suite 375 Valencia, CA 91355 Phone: (661) 253-7400	Northern Los Angeles County, Santa Barbara and Ventura

SECTION FOUR: WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

The Workers' Compensation Fraud Program is the largest of five statewide anti-fraud programs under the administration and the investigative arm of the Fraud Division.

Distribution of Workers' Compensation Fraud Program Hours

For Fiscal Year 2010-11, investigative staff spent 80.2 percent of program hours on case and direct/program support; the remaining 6.0 percent was indirect time and 13.8 percent was time off.

The Fraud Division spent 45 percent of its time directly on the Workers' Compensation Fraud Program, while the remaining 55 percent was distributed throughout the other insurance fraud programs. In addition to investigative activities, the Fraud Division is responsible for the administration and oversight of the program which includes:

- Local Assistance grant management
- SIU compliance
- District attorney grant audits
- Legislative statistical and analytical reporting
- Research
- Legal services (public request acts, opinions, qui tams, rulemaking, etc.)
- Legislation support and analyses
- Budget monitoring and proposals
- Property/evidence control
- Fraud Assessment Commission support

Maintaining a Balanced Caseload

Each Fraud Division Regional Office's caseload is representative of the demographics within their area of responsibility and jurisdiction. Working in conjunction with the district attorneys, each regional office selects cases that will have the most significant impact on the insurance fraud problem in their area of responsibility. These cases include medical/legal provider, premium fraud, employer-defrauding employee, insider fraud, claimant fraud, underreported wages, uninsured employer, and X-Mod evasion. Enforcement efforts continue to focus on high impact fraud cases such as medical/legal provider, premium fraud, and the willfully uninsured.

Workers' Compensation Caseload - Fiscal Year 2010-11

Fraud Activity Type	Total Caseload
Claimant Fraud	523
Insider Fraud	8
Employer Defrauding Employee	36
Legal Provider	4
Medical Provider	56
Misclassification	43
Other Workers' Comp	87
Pharmacy	4
Underreported Wages	201
Uninsured Employer	372
X-Mod Evasion	9
Grand Total	1,343

Underground Economy

Underground economy is a term that refers to those individuals and businesses that deal with cash and/or use other schemes to conceal their activities and their true tax liability from government licensing, regulatory, and taxing agencies. Underground economy is also referred to as tax evasion, tax fraud, cash pay, tax gap, payments under-the-table, and off the books.

When businesses operate in the underground economy, they illegally reduce the amount of money expensed for insurance, payroll taxes, licenses, employee benefits, safety equipment, and safety conditions. These types of employers then gain an unfair competitive advantage over businesses that comply with the various business laws. This causes unfair competition in the marketplace and forces law-abiding businesses to pay higher taxes and expenses.

On October 26, 1993, the Governor signed Executive Order W-66-93, which created the Joint Enforcement Strike Force (JESF) on the Underground Economy. The Governor subsequently signed Senate Bill 1490, which placed the provisions of the Executive Order into law as Section 329 of the California Unemployment Insurance Code, effective January 1, 1995.

The JESF is responsible for enhancing the development and sharing of information necessary to combat the underground economy, to improve the coordination of enforcement activities, and to develop methods to pool, focus, and target enforcement resources. The JESF is empowered and authorized to form joint enforcement teams when appropriate to utilize the collective investigative and enforcement capabilities of the JESF members.

In addition to the Employment Development Department, the other Strike Force members include Department of Consumer Affairs, Department of Industrial Relations, Department of Insurance, Franchise Tax Board, Board of Equalization, and Department of Justice.

The JESF obtains information through a number of sources, which indicate that a business may be operating illegally. These sources include hot line referrals, complaints from legitimate businesses, and information sharing through collaborating agencies' databases. The JESF conducts joint on-site business investigations to identify employers operating in the underground economy. The goal is to identify and bring into compliance those individual and businesses participating in the underground economy that are in violation of payroll tax, labor, licensing laws and workers' compensation insurance premium.

Underground Economy Roofers Project

In May 2010, a joint enforcement project was proposed at a JESF meeting. The concept is to focus on C-39 roofing contractors. Recent legislation requires that all C-39 roofing contractors carry adequate workers' compensation insurance coverage for their employees or a Certificate of Self-Insurance. Lack of workers' compensation insurance is a serious problem for roofing company employees and sole-owner roofers.

Additionally, it causes unfair competition for the many C-39 contractors who obey California workers' compensation and safety laws, as well as unemployment insurance, permit, wage, and work hour regulations. The project is targeted on illegal activity of these C-39 roofing contractors who may be involved in premium insurance fraud by not accurately reporting the number of people they employ and who are also failing to comply with Business and Professions Code Section 7125 which requires contractors to carry workers' compensation insurance. The project also focuses on C-39 roofing contractors who have minimal workers' compensation insurance policy and may be violating the Employment Development Department's employer tax laws, premium fraud statutes, and Contractor State Licensing Board licensing laws. Investigators from these agencies and local district attorneys are involved and focused on four selected counties: Alameda, Fresno, San Diego, San Mateo, and two additional alternate counties of Riverside and San Bernardino.

State Operations – Budget

Workers' Compensation Fraud Program Budget Fiscal Year 2010-11 103 Personnel Years (PY)

Personal Services	\$10,105,215
Operating Expenses & Equipment (OE&E)	\$2,997,095
CDI Administrative Support	\$3,579,015
Total.....	<u>\$16,681,325</u>

Unfunded Contributions

The Department continually provides funding for the workers' compensation anti-fraud efforts in areas that are not funded by the workers' compensation fraud grant. The Department funds investigations by the Enforcement Branch's Investigation Division into allegations of misdeeds by brokers and agents. These investigations look at brokers and agents who have violated their fiduciary responsibility by stealing or misappropriating premiums received from employers for the purchase of workers' compensation coverage. The costs for the investigation of these cases is derived from fees and licensing funds within the Department.

In addition to the investigation of cases involving brokers and agents, the computer forensics team (CFT) members routinely assist the Fraud Division during search warrants. They are often called upon to assist with the acquisition of computer related evidence. These CFT members later assist in extracting information from the acquired evidence. The cost of funding these positions is also derived from fees and licensing.

Program Support

- Insurance Commissioner's Office
- Statewide Pro Rata (e.g., Governor's Office, Legislature, etc.)
- Legal Branch
- Budget and Revenue Management Bureau
- Human Resources Management Division
- Accounting Services Bureau
- Communications & Press Relations
- Information Technology Division
- Business Management Bureau

Staffing

In Fiscal Year 2010-11, the Fraud Division expended 103 workers' compensation personnel years.

SECTION FIVE: WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM APPENDICES

1. Fiscal Year 2010 -11 Local Assistance Grant Funding by County
2. Suspected Fraudulent Claims for Calendar Years 2009 through 2011
3. Fiscal Year 2010 -11 District Attorney Convictions

Appendix 1
Workers' Compensation Insurance Fraud Program
Insurance Commissioner's Funding Recommendation - Fiscal Year 2010-11

County	Carry-Over Funds (Based on Audit Report FY 2008-09)	Funding 2009-10	Total Funds Available For 2009-10	Funding Requested	Insurance Commissioner's Funding Recommendation 2010-11
Alameda	\$20,838	\$1,273,874	\$1,294,712	\$1,367,428	\$1,273,874
Amador	\$119	\$460,000	\$460,119	\$509,487	\$425,000
Butte	\$0	\$200,000	\$200,000	\$217,887	\$200,000
Contra Costa	\$0	\$600,000	\$600,000	\$756,156	\$625,000
El Dorado	\$14,505	\$275,000	\$289,505	\$446,872	\$275,000
Fresno	\$160,309	\$1,180,000	\$1,340,309	\$1,404,835	\$1,180,000
Humboldt	\$0	\$240,000	\$240,000	\$265,989	\$235,000
Imperial	\$7,470	\$65,000	\$72,470	\$62,722	\$45,000
Kern	\$231,818	\$900,000	\$1,131,818	\$687,065	\$687,065
Kings	\$0	\$282,673	\$282,673	\$306,084	\$282,673
Los Angeles	\$269,920	\$5,067,032	\$5,336,952	\$5,254,172	\$5,000,000
Madera	\$5,930	\$46,185	\$52,115	\$42,834	\$42,000
Marin	\$22,037	\$200,000	\$222,037	\$201,166	\$200,000
Mendocino	\$0	\$70,000	\$70,000	\$70,000	\$46,653
Merced	\$36,673	\$150,000	\$186,673	\$146,160	\$140,000
Monterey	\$0	\$500,000	\$500,000	\$568,876	\$520,000
Napa				\$121,115	\$85,000
Orange	\$7,628	\$3,114,894	\$3,122,522	\$3,980,142	\$3,190,000
Riverside	\$856	\$1,130,000	\$1,130,856	\$1,554,685	\$1,225,000
Sacramento	\$38,569	\$900,000	\$938,569	\$1,135,845	\$900,000
San Bernardino	\$133,638	\$2,151,640	\$2,285,278	\$2,193,413	\$2,173,413
San Diego	\$835,430	\$4,800,000	\$5,635,430	\$5,070,931	\$4,825,000
San Francisco	\$128,544	\$775,000	\$903,544	\$885,665	\$800,000
San Joaquin	\$0	\$580,000	\$580,000	\$600,372	\$580,000
San Luis Obispo	\$0	\$94,000	\$94,000	\$209,523	\$0
San Mateo	\$1,904	\$525,000	\$526,904	\$818,106	\$525,000
Santa Barbara	\$63,588	\$300,000	\$363,588	\$368,668	\$290,000
Santa Clara	\$0	\$2,153,365	\$2,153,365	\$2,555,035	\$2,153,365
Santa Cruz	\$0	\$125,000	\$125,000	\$124,731	\$120,000
Shasta	\$0	\$162,127	\$162,127	\$228,241	\$150,000
Siskiyou	\$0	\$26,170	\$26,170	\$30,326	\$26,170
Solano	\$0	\$175,000	\$175,000	\$175,000	\$175,000

Appendix 1 (continued)

**Workers' Compensation Insurance Fraud Program
Insurance Commissioner's Funding Recommendation - Fiscal Year 2010-11**

County	Carry-Over Funds (Based on Audit Report FY 2008-09)	Funding 2009-10	Total Funds Available For 2009-10	Funding Requested	Insurance Commissioner's Funding Recommendation 2010-11
Sonoma	\$0	\$98,735	\$98,735	\$104,119	\$98,735
Tehama	\$0	\$30,556	\$30,556	\$113,345	\$65,000
Tulare	\$90,075	\$317,950	\$408,025	\$313,937	\$313,937
Tuolumne	\$0	\$20,000	\$20,000	\$20,000	\$0
Ventura	\$0	\$724,615	\$724,615	\$729,298	\$724,615
Yolo	\$0	\$172,591	\$172,591	\$252,325	\$230,000
TOTAL	\$2,069,851	\$29,886,407	\$31,956,258	\$33,892,555	\$29,827,500

Appendix 2

Workers' Compensation Insurance Fraud Reported Suspected Fraudulent Claims 2009, 2010, and 2011

County	2009 SFC's	2010 SFC's	2011 SFC's	TOTAL
Alameda	216	207	191	614
Alpine	0	1	1	2
Amador	2	3	1	6
Butte	16	24	25	65
Calaveras	0	0	4	4
Colusa	3	2	2	7
Contra Costa	119	109	109	337
Del Norte	3	3	4	10
El Dorado	16	14	19	49
Fresno	95	134	158	387
Glenn	1	2	3	6
Humboldt	7	12	10	29
Imperial	15	24	27	66
Inyo	0	1	2	3
Kern	62	101	123	286
Kings	19	21	23	63
Lake	11	6	6	23
Lassen	4	8	8	20
Los Angeles	1,704	2,270	1,987	5,961
Madera	14	13	23	50
Marin	28	44	32	104
Mariposa	1	0	0	1
Mendocino	10	25	13	48
Merced	13	17	29	59
Modoc	0	0	1	1
Mono	0	0	0	0
Monterey	76	93	64	233
Napa	17	24	18	59
Nevada	5	16	13	34
Orange	404	445	480	1,329
Placer	26	39	37	102

Appendix 2 (continued)

Workers' Compensation Insurance Fraud Reported Suspected Fraudulent Claims 2009, 2010, and 2011

County	2009 SFC's	2010 SFC's	2011 SFC's	TOTAL
Plumas	3	0	3	6
Riverside	223	294	311	828
Sacramento	121	144	166	431
San Benito	6	7	1	14
San Bernardino	301	400	352	1,053
San Diego	269	378	333	980
San Francisco	92	78	102	272
San Joaquin	41	57	63	161
San Luis Obispo	30	20	29	79
San Mateo	66	92	76	234
Santa Barbara	31	40	60	131
Santa Clara	153	158	163	474
Santa Cruz	40	48	27	115
Shasta	12	24	38	74
Sierra	0	0	0	0
Siskiyou	2	4	3	9
Solano	35	40	33	108
Sonoma	51	52	53	156
Stanislaus	29	45	50	124
Sutter	9	8	7	24
Tehama	2	9	8	19
Trinity	1	0	1	2
Tulare	27	45	43	115
Tuolumne	4	7	3	14
Ventura	104	112	118	334
Yolo	16	19	27	62
Yuba	3	9	4	16
TOTAL	4,558	5,748	5,487	15,793

Appendix 3

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Alameda County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
H48947	Alatini, Sione	Uninsured Employer	1 day(s) jail 60 month(s) probation		\$3,000	\$0
426673	Allums, Charles	Other	1 day(s) jail 36 month(s) probation		\$0	\$2,900
134404	Badilla, Gilbert	Uninsured Employer	1 day(s) jail 36 month(s) probation 40 hour(s) community service		\$0	\$1,500
426667	Beddawi, Joseph	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000
558933	Cabello, Lorenzo	Claimant Fraud	73 day(s) jail 36 month(s) probation		\$0	\$0
H49510	Carter, Deborah	Claimant Fraud	1 day(s) jail 60 month(s) probation		\$500	\$2,500
H48219	Chandler, Latoya	Claimant Fraud	1 day(s) jail 60 month(s) probation 1,100 hour(s) of community service		\$315	\$0
H49310	Chavez, Alex	Claimant Fraud	1 day(s) jail 60 month(s) probation		\$0	\$0
H50697	Cruz, Jennie	Claimant Fraud	30 day(s) jail 60 month(s) probation 240 hour(s) community service		\$50,000	\$1,000
430488	Douzane, Djamal	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000
H50332	Fabiani, Fabricio	Other	30 day(s) jail 60 month(s) probation		\$0	\$3,500
426671	Farrell, Steven	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,500

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Alameda County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
430484	Gahla, Sandeep	Other	36 month(s) probation		\$0	\$1,000
H50156	Garrick, Carlyle	Uninsured Employer	16 day(s) jail 60 month(s) probation		\$5,500	\$1,000
430487	Godinez, Rolando	Other	36 month(s) probation		\$0	\$1,000
H49146	Gomez, Albaro	Uninsured Employer	180 day(s) jail 60 month(s) probation		\$98,425	\$1,200
426990	Groark, Susan	Claimant Fraud	36 month(s) probation 100 hour(s) community service		\$24,778	\$5,000
424390A	Haddad, Joseph	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$500
131250	Havea, Tevisi	Uninsured Employer	5 day(s) jail 36 month(s) probation		\$3,000	\$0
H50120	Henry, John	Claimant Fraud	15 day(s) jail 60 month(s) probation		\$0	\$0
428694	Hernandez, Job	Other	5 day(s) jail 36 month(s) probation		\$2,150	\$5,000
H49798	Lantican, Victor	Claimant Fraud	1 day(s) jail 60 month(s) probation		\$7,547	\$500
426679	Lopez-Ortiz, Jose	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000
419837	Lynch, Kelly	Claimant Fraud	2 day(s) jail 24 month(s) probation 160 hour(s) community service		\$10,932	\$1,000
426670	Maldonado, Lesa	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Alameda County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
H50202	Martinez, Armondo	Claimant Fraud	29 day(s) jail 60 month(s) probation		\$12,644	\$200
426674	Mauldin, Michael	Other	1 day(s) jail		\$0	\$500
426668	Mayorga, Gabriel	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,500
426678	Moore, Joseph	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,500
426675	Ortega, Daniel	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,688
426681	Phan, Minh	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000
133093	Regacho, Maria	Claimant Fraud	2 day(s) jail 60 month(s) probation		\$10,000	\$0
426669	Rivera, Ruben	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000
429789	Romero, Julio	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$0	\$0
419082B	Ruan, Joey	Premium Fraud	3 day(s) jail 36 month(s) probation 240 hour(s) community service		\$10,000	\$3,000
426672	Sanchez, Manuel	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,000
426680	Sandoval, Jose	Other	1 day(s) jail 36 month(s) probation		\$0	\$1,688
133103	Tanti, David	Claimant Fraud	1 day(s) jail 60 month(s) probation		\$7,500	\$0

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Alameda County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
237006	Tonna, Robert	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$1,650	\$2,500
H50407	Ung, Monica	Premium Fraud	1 day(s) jail 120 month(s) probation	\$4,000,000	\$1,559,000	\$0
422949	Van Eyck, Nicholas	Claimant Fraud	5 day(s) jail 36 month(s) probation 40 hour(s) community service		\$3,000	\$750
165930	Williams, Orlando	Claimant Fraud	90 day(s) jail 60 month(s) probation		\$0	\$0
419082C	Wu, Tin Wai	Premium Fraud	36 month(s) probation 150 hour(s) community service		\$4,000	\$3,000

Amador County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
62-99184	Bravo, Ruben	Uninsured Employer	45 day(s) jail 24 month(s) probation		\$0	\$2,500
62-97324	Britton, Joe	Uninsured Employer	12 month(s) probation		\$0	\$1,000
62-92227	Chambers, William	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,500
62-94958	Earles, Cory	Uninsured Employer			\$0	\$1,500
62-102046	Fenno, Brian	Uninsured Employer	12 month(s) probation		\$0	\$100
10CR17422	Gross, Brian	Uninsured Employer	1 day(s) jail 48 month(s) probation 600 hour(s) community service		\$0	\$2,500

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Amador County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
62-99755	Mccooy, Matthew	Other	30 day(s) jail 12 month(s) probation		\$0	\$1,000
10CR17118	Moniz, Tymm	Uninsured Employer	12 month(s) probation		\$0	\$1,660
62-100342	Nickel, Patrick	Uninsured Employer			\$0	\$3,000
62-94957	Richardson, Daniel	Uninsured Employer	12 month(s) probation		\$0	\$2,500
62-94411	Scott, Jeffery	Uninsured Employer	36 month(s) probation 30 hour(s) community service		\$0	\$3,000
62-105055	Warner, Robert	Uninsured Employer			\$0	\$750
10CR17309	Windley, Wesley	Uninsured Employer	24 month(s) probation		\$1,270	\$8,160

Butte County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
SCR80163	Osorio, Raul	Uninsured Employer	36 month(s) probation		\$0	\$0
CM33481	Sullivan-Brumba, Misty	Other	1 day(s) jail 36 month(s) probation		\$490	\$0

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Contra Costa County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
1-150108-9	Bellido, Carlos	Uninsured Employer	24 month(s) probation		\$0	\$1,500
C10-03097	Calderon, Santiago Hernandez / Santiago's Yardwork	Uninsured Employer	Permanent Civil Injunction		\$0	\$400
1-151771-3	Carbajal, Enrique	Uninsured Employer	12 month(s) probation		\$0	\$1,170
1-145506-2	Ceron, Lazaro	Uninsured Employer	12 month(s) probation		\$0	\$750
N10-1922	Fameitau, Sione Uaine	Uninsured Employer	Permanent Civil Injunction		\$0	\$1,100
1-150974-4	Goff, Steven	Uninsured Employer	24 month(s) probation		\$0	\$1,170
1-143486-9	Haro, Miguel	Uninsured Employer	12 month(s) probation		\$0	\$750
C09-01840	Kim, Insu / Kim's Landscaping	Uninsured Employer	Civil Permanent Injunction		\$0	\$2,000
3-222250-3	Lee, Chrishon	Claimant Fraud	24 month(s) probation 40 hour(s) community service		\$1,200	\$0
1-147676-1	Paulu, Viliami	Uninsured Employer	10 day(s) jail 24 month(s) probation		\$0	\$2,160
1-150957-9	Pimental, Martin	Uninsured Employer	24 month(s) probation		\$0	\$1,070
N10-1972	Reynoso, Felipe	Uninsured Employer	Permanent Civil Injunction		\$0	\$400
1-150970-1	Romero, Esteban	Uninsured Employer	24 month(s) probation		\$0	\$1,670

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Contra Costa County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C10-02979	Roxy's Designs	Uninsured Employer	Permanent Injunction		\$0	\$400
1-151779-6	Shahim, Mohammand	Uninsured Employer	24 month(s) probation 150 hour(s) community service		\$14,554	\$170
4-164418-6	Tangitau, Oto Emili	Uninsured Employer	24 month(s) probation 150 hour(s) community service		\$3,700	\$260

El Dorado County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
P10CRM1449	Baxter, David Frederick / Baxter Garage Door & Gate	Other	24 month(s) probation		\$0	\$921
P10CRF0414	Borrowman, Carl / Custom Drywall Work	Uninsured Employer	45 day(s) jail 36 month(s) probation		\$0	\$2,019
P11CRM0194	Brown, Joseph Daniel / Heavenly Gondola Lodge	Uninsured Employer	12 month(s) probation		\$0	\$956
P10CRM1450	Castillo, Oscar D. / Castillo's Landscaping	Other	24 month(s) probation		\$0	\$956
P10CRM0448	Cipriano, Crescencio Moreno / A-1 Landscaping	Other	24 month(s) probation		\$0	\$705
P10CRM1456	Cortez, Macario Ramirez / Macario Tree & Landscaping Services	Other	24 month(s) probation		\$0	\$987
P11CRM0195	Crews, Timothy James / Precision Concrete	Uninsured Employer	24 month(s) probation		\$0	\$558

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

El Dorado County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
P10CRM0176	Fernandez, Francisco / Pacific Landscape Maintenance	Uninsured Employer	24 month(s) probation		\$0	\$250
P10CRM1058	Gallman, Joshua Ryan / Josh's Flooring	Uninsured Employer	24 month(s) probation		\$0	\$539
P10CRM0938	Garcia, Francisco / Francisco Garcia Gardening	Uninsured Employer	24 month(s) probation		\$0	\$532
P10CRM0927	Gonzalez, Ruben Santos / Santos Gardening	Uninsured Employer	24 month(s) probation		\$0	\$100
P10CRM0549	Habedank, Renee Marie / Habedank Tree Service	Uninsured Employer	36 month(s) probation		\$0	\$975
P09CRF0432	Halk, Richard Lee / Halk's Equipment Rental	Uninsured Employer	24 month(s) probation		\$0	\$500
P10CRM1457	Herrenschmidt, Martin / Quality Painting & Repairs Git Er Done	Other	24 month(s) probation		\$0	\$987
10-11-6092	Hicks, Thomas Wayne / Bobcat Express	Other	24 month(s) probation		\$0	\$856
P10CRM1455	Hildebrand, Kenneth Lee / Hildebrand And Son	Other	24 month(s) probation		\$0	\$956
P10CRM1454	Hoff, Ben David / Asphalt Sealcoating	Uninsured Employer	36 month(s) probation		\$0	\$856
P10CRM1591	Jabour, Richard / Jabour Building & Remodeling	Uninsured Employer	24 month(s) probation		\$0	\$558
P10CRM1548	Kenner, Michael Earl / House Doctor	Uninsured Employer	24 month(s) probation		\$0	\$956

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

El Dorado County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
P11CRM0207	Kim, Eun / One Stop Cleaners	Uninsured Employer	24 month(s) probation		\$0	\$3,000
P10CRM0803	Langan, Robert / Bob Langan Designs	Uninsured Employer	24 month(s) probation		\$0	\$500
P10CRM0998	Laughlin, John Mark	Uninsured Employer	24 month(s) probation		\$0	\$294
P10CRM1078	Longo, Joseph John / Longo Construction Company	Uninsured Employer	24 month(s) probation		\$0	\$100
P08CRM1046	Marino, Paul Wayne	Uninsured Employer	24 month(s) probation		\$0	\$401
P09CRF0127	Mejia, Fernando	Other	24 month(s) probation		\$5,150	\$0
P09CRF0321	Mejia, Fernando / Cameron Park Remodel	Other	150 day(s) jail 36 month(s) probation		\$31,266	\$400
P10CRM0441	Meza, Agripino	Other			\$0	\$250
10-11-6016	Moore, Shawn / Shawn's Automotive	Uninsured Employer	24 month(s) probation		\$0	\$558
P10CRM1538	Moran, Ignacio Hernandez / Moran's Tree Service	Other	24 month(s) probation		\$0	\$856
P10CRM0480	Ogino, James Patrick / Ogino Family Landscape	Other	12 month(s) probation		\$0	\$846
P10CRM1549	Oliveros, Quirino / Vino Tree Service	Uninsured Employer	30 day(s) jail 36 month(s) probation		\$0	\$856
P10CRM1590	Olson, Clinton / Olson Fencing	Uninsured Employer	24 month(s) probation		\$0	\$458

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

El Dorado County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
P10CRM1458	Padilla, Chen Maui / Sierra Bushmen	Uninsured Employer	24 month(s) probation		\$0	\$956
P10CRM1093	Pepper, Joel Royce / All Treez	Uninsured Employer	36 month(s) probation		\$0	\$0
P10CRM0628	Riley, Stephen Howard / Taylor Made Exteriors	Uninsured Employer	24 month(s) probation		\$500	\$0
P10CRM0885	Rivera, Victor Paris / Paintbrush Co.	Uninsured Employer	24 month(s) probation		\$0	\$366
P10CRM1091	Schostag, Jason David / Woodworks Unlimited	Uninsured Employer	12 month(s) probation		\$0	\$300
P11CRM0050	Shewmake, Thomas John / Duration Roof Repair	Uninsured Employer	24 month(s) probation		\$0	\$0
P10CRM0158	Smith, Mark Alan / El Dorado Design & Build	Uninsured Employer	12 month(s) probation		\$0	\$300
P10CRF0173	Spence, Viola Janet	Claimant Fraud	36 month(s) probation		\$1,018	\$100
P10CRM1318	Suela, Randy / RS Masonry	Uninsured Employer	24 month(s) probation		\$0	\$100
P10CRM1061	Varga, Istvan Janos / West Coast Painting	Uninsured Employer	36 month(s) probation		\$0	\$500
P10CRM1319	Williams, George / American River Plumbing	Uninsured Employer	24 month(s) probation		\$0	\$125
P10CRM0920	Williams, Gerald Wade / Granite Bay Landscape	Uninsured Employer	24 month(s) probation		\$0	\$450
P10CRM1466	Worthen, Troy Daniel / Mountain Tractor Service	Uninsured Employer	24 month(s) probation		\$0	\$856

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Fresno County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
11-6330	Celedon, Juan	Other	12 month(s) probation		\$500	\$0
11-7027	Chavana, Ramiro	Uninsured Employer	12 month(s) probation		\$1,500	\$0
11-7020	Cruz, Sergio	Uninsured Employer	12 month(s) probation		\$1,500	\$0
10-16009	Deanda, Vincent	Other	12 month(s) probation		\$500	\$0
09-45864	Esquivel, Sosimo	Claimant Fraud	6 month(s) probation 50 hour(s) community service		\$1,020	\$205
10-20862	Fraser, Deberah	Claimant Fraud	6 month(s) probation		\$2,968	\$100
10-6813	Garner, Bryan Earl	Uninsured Employer	12 month(s) probation		\$500	\$0
09-14194	Ghazal, Jay	Uninsured Employer	12 month(s) probation		\$1,500	\$0
10-27432	Gonzalez, Juan	Claimant Fraud	90 day(s) jail 60 month(s) probation		\$16,725	\$271
11-6322	Heredia, Christian	Other	12 month(s) probation		\$500	\$0
11-7050	Martin, Daniel	Other	12 month(s) probation		\$500	\$0
10-16810	Matthews, Lewis F	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$6,177	\$400
11-6332	Montejano, Gilbert	Other	12 month(s) probation		\$500	\$0

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Fresno County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10-16036	Renteria, Richard Anthony	Other	6 month(s) probation		\$0	\$0
10-16129	Reyes, Gregory Paul	Other	12 month(s) probation		\$500	\$0
07-13053	Rios, Armando David	Claimant Fraud	60 month(s) probation		\$650,000	\$660
09-43890	Rios, Ronnie Joseph	Uninsured Employer	365 day(s) jail 36 month(s) probation		\$2,500	\$0
11-7039	Rodriquez, Arturo	Uninsured Employer	12 month(s) probation		\$500	\$0
10-38242	Rose, Ryan	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$4,294	\$0
10-8235	Rush Jr., Thomas Edward	Other	365 day(s) jail 36 month(s) probation		\$500	\$0
10-20805	Valera, Maria Yoland	Claimant Fraud	36 month(s) probation		\$500	\$0
09-14289	Wright, Billie E	Claimant Fraud	60 month(s) probation		\$68,054	\$600

Kern County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BM780739A	Branch, Veronica / Summerbreez	Uninsured Employer	36 month(s) probation		\$10,000	\$415
BM782572A	Chavez-Vilegas, Jose	Uninsured Employer	6 day(s) jail 36 month(s) probation		\$0	\$915

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Kern County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BF127872C	Dodd, James Carol	Other	365 day(s) jail		\$45,994	\$60
BF127782A	Dodd, Shawn Renee / Royal Medical Management	Multiple Entities Provider Fraud	72 month(s) prison	\$203,953	\$2,296,351	\$300
BM774145A	Dow, Ande Mark	Other	90 day(s) jail 36 month(s) probation		\$0	\$5,100
BF130389A	Ebersole, Chance / Chance's Tree Service	Premium Fraud	180 day(s) jail 36 month(s) probation		\$115,220	\$230
BF121732A	Martinez, Beatrice	Premium Fraud	4 day(s) jail 60 month(s) probation		\$19,366	\$0
BF129935A	Pettit, Timmy Roland	Claimant Fraud	365 day(s) jail 60 month(s) probation		\$65,000	\$525
BM768218a	Ruiz, Santiago Gonzalez	Uninsured Employer	180 day(s) jail 36 month(s) probation		\$0	\$600
BF129521A	Salinas, Miles Peter	Claimant Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$14,848	\$525
BM780215A	Villareal, Adrian Joshue	Uninsured Employer	5 day(s) jail 36 month(s) probation		\$0	\$915
BM779414A	Villareal, Candido	Uninsured Employer	120 day(s) jail 36 month(s) probation		\$0	\$5,940

Kings County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
11-1534	Aispuro, Manuel	Other	36 month(s) probation		\$0	\$1,200

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Kings County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10-1161	Campos, Joe	Other	12 month(s) probation		\$0	\$720
11-1533	Dart, Christopher	Uninsured Employer	36 month(s) probation		\$0	\$1,064
11-1542	Faccinto, Anthony	Uninsured Employer	36 month(s) probation		\$0	\$688
10-0965	Gonzalez, Antonio	Other			\$0	\$420
10-0970	Herrera, Jose	Other	36 month(s) probation		\$0	\$720
11-1540	Houts, James	Other	36 month(s) probation		\$0	\$688
10-3251	Hulbert, John	Other	36 month(s) probation		\$2,526	\$2,520
10-0971	Mayfield, Russell	Other	24 month(s) probation		\$0	\$720
10-1162	Mejorado, Jehu	Other	36 month(s) probation		\$0	\$1,830
08-2625	Ramos, Carl	Claimant Fraud	1 day jail 36 month(s) probation		\$31,087	\$617
11-1538	Ware, Kenneth	Other	36 month(s) probation		\$0	\$688
11-1539	Withnell, Kenneth	Other	36 month(s) probation		\$0	\$688

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Los Angeles County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BA354985	Adams, Nancy Lockwood / Team Staffing	Premium Fraud	60 month(s) probation 500 hour(s) community service		\$3,326,462	\$480
1RI01322	Alvillar, Miguel / Tacos El Chaparrito	Uninsured Employer	24 month(s) probation		\$100	\$3,000
0AH04885	Attallah, Mariam / Virgin Mary Preschool	Uninsured Employer	24 month(s) probation		\$0	\$3,000
BA374978	Ayala, Waldo Rolando	Other	7 day(s) jail 36 month(s) probation		\$100	\$1,000
BA355293	Barahona, Jimmy H. / Mainstay Business Solutions	Claimant Fraud	1 day jail 100 hour(s) community service		\$5,000	\$200
BA369503	Benhain, Motti / Omega Security Services and Consultants Inc	Claimant Fraud	36 month(s) probation		\$118,476	\$200
1AH01101	Cao, Ashley / Cafe Window	Uninsured Employer	24 month(s) probation		\$100	\$3,000
BA382525	Castaneda, Maria D. / Dirksen	Claimant Fraud	1 day jail 36 month(s) probation 100 hour(s) community service		\$1,000	\$2,000
0EA12278	Cervantes, Antonio / JCG Auto Service	Uninsured Employer	24 month(s) probation		\$0	\$3,000
0NW00691	Chang, Hye Soon / Wayman Cleaners	Uninsured Employer			\$0	\$585
BA375878	De Leon, Peter / Consolidated Disposal Service	Claimant Fraud	60 month(s) probation		\$200,000	\$200
BA377256	De Santiago, Edgar / Six Flags	Claimant Fraud	24 month(s) probation		\$2,263	\$100
BA383122	Del Carmen, Hernan / Sun Valley Jersey Dairy	Claimant Fraud	72 day(s) jail 36 month(s) probation		\$7,733	\$200

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Los Angeles County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BA367122	Dominguez, Ruben	Multiple Entities Provider Fraud	12 day(s) jail 60 month(s) probation		\$4,700,000	\$320
1RI01323	Fernandez, Jose Jesus / El Mercadito Del Pueblo	Uninsured Employer	24 month(s) probation		\$0	\$3,000
BA382414	Flores, Manuel / Mac Casualty LTD-Tomra Pacific Zone	Claimant Fraud	36 month(s) prison 3 day(s) jail 36 month(s) probation 40 hour(s) community service		\$0	\$200
BA373554	Fuentes, Saul Argueta	Other	9 day(s) jail 36 month(s) probation		\$0	\$0
BA374978	Garcia, Walter Ulises	Other	36 month(s) probation 100 hour(s) community service		\$0	\$1,000
BA383047	Gatatho, Waliga / Spring Time Fashion Inc.	Premium Fraud	24 month(s) probation		\$6,750	\$0
BA373799	Gaut, Donnie L. / UC Irvine Medical Center	Claimant Fraud	36 month(s) probation 200 hour(s) community service		\$0	\$1,000
BA379285	Gazafy, Carl J. / Downey Ford, Inc.	Claimant Fraud	2 day(s) jail 36 month(s) probation		\$7,905	\$200
1PK01179	Gonzalo-Reyes, Gil / Tacos Mexico	Uninsured Employer	24 month(s) probation		\$0	\$3,000
BA379104	Gurrola, Jorge I. / J Gurrola Construction	Premium Fraud	1 day(s) jail 36 month(s) probation		\$34,225	\$200
BA379104	Gurrola, Maria / J Gurrola Construction	Premium Fraud	1 day(s) jail 24 month(s) probation		\$0	\$200
BA379107	Gutierrez, Benjamin / Sunwest Clean Up, Inc	Premium Fraud	2 day(s) jail 36 month(s) probation		\$54,745	\$200
OJB10099	Gutierrez, Jesus Francisco / Las Milpas Restaurant	Uninsured Employer	24 month(s) probation		\$0	\$3,000

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
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Los Angeles County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BA355029	Guzman, Luis E. / Nordstrom, Inc.	Claimant Fraud	43 day(s) jail 60 month(s) probation		\$9,900	\$200
BA353660	Hammond, Irma A. / Wells Fargo Bank	Claimant Fraud	2 day(s) jail 36 month(s) probation 200 hour(s) community service		\$3,261	\$685
BA369513	Hargrave, Timothy R. / City of Los Angeles	Claimant Fraud	1 day(s) jail 36 month(s) probation 250 hour(s) community service		\$26,285	\$200
BA367122	Hauf, Heinz Juergen	Multiple Entities Provider Fraud	365 day(s) jail 60 month(s) probation		\$4,841,688	\$200
BA374292	Inda, Jaime Rocha / U.S. Post Office	Claimant Fraud	36 month(s) probation 100 hour(s) community service		\$4,600	\$0
BA239839	Iniguez, Felipe	Claimant Fraud			\$5,000	\$100
BA367841	Jordan, Kevin / DSL Construction Corp.	Claimant Fraud	7 day(s) jail 60 month(s) probation		\$14,000	\$200
1RI00378	Karnsomport, Somyos / Rush Street Market and Liquor	Claimant Fraud	24 month(s) probation		\$0	\$3,000
1PK01526	Kim, Jung Ho / Uno Mart	Uninsured Employer	24 month(s) probation		\$100	\$3,000
1AH00671	Lam, Kelly Hoang / Hanh Hoa Cafe	Uninsured Employer	24 month(s) probation		\$100	\$3,000
BA380140	Leon, Patricia Elena / Hacienda La Puente USD	Claimant Fraud	2 day(s) jail 60 month(s) probation		\$8,800	\$200
1AH00636	Lin, Mei Ling / Nine Six Health Center	Uninsured Employer	24 month(s) probation		\$0	\$3,000
BA367122	Lopez, Arturo	Multiple Entities Provider Fraud	48 month(s) prison		\$4,700,000	\$200

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Los Angeles County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BA369932	Luquin, Jose / Timco Aviation Sales	Claimant Fraud	36 month(s) probation 40 hour(s) community service		\$4,175	\$0
BA374088	Mack, Dawn / Children's Collective Inc.	Claimant Fraud	200 hour(s) community service		\$5,400	\$0
BA368532	Marquis, Jr., Richard T. / Chem Mark of Long Beach, Inc.	Claimant Fraud	60 month(s) probation 120 hour(s) community service		\$380	\$260
BA367122	Martinez, Joseph	Multiple Entities Provider Fraud	180 day(s) jail 60 month(s) probation		\$4,841,688	\$200
BA367122	Martinez, Soledad	Multiple Entities Provider Fraud	180 day(s) jail 60 month(s) probation		\$4,841,688	\$200
BA355060	Mendez, Gilberto / Super A Foods, Inc.	Claimant Fraud	24 month(s) probation		\$8,486	\$100
BA367913	Miranda, Eloy / City of Lynwood	Claimant Fraud	4 day(s) jail 36 month(s) probation		\$5,000	\$200
BA367136	Navarro, Yesmin / Martin Luther King Hospital	Claimant Fraud	1 day(s) jail 24 month(s) probation		\$17,000	\$100
OJB10162	Nevarez, Jose L. / La Puente Radiator & Body	Uninsured Employer	24 month(s) probation		\$0	\$3,000
1RI00799	Nguyen, Cindy / Coffee House	Uninsured Employer	24 month(s) probation		\$0	\$2,000
1PK01527	Nguyen, Thanhloan Thi / Mommy & Baby Nutrition	Uninsured Employer	24 month(s) probation		\$0	\$3,000
1RI01447	Nguyen, Thomas Phat / Best Tax and Financial	Uninsured Employer	24 month(s) probation		\$200	\$2,000
BA376217	Ochoa, Maria	Multiple Entities Provider Fraud	267 day(s) jail 36 month(s) probation		\$321,200	\$200

Appendix 3 (continued)
Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011
Los Angeles County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BA376217	Orozco, Sandra	Multiple Entities Provider Fraud	17 day(s) jail 36 month(s) probation 200 hour(s) community service		\$885,241	\$200
1PK01178	Osman, Karl / 94 Cent Discount	Uninsured Employer	24 month(s) probation		\$100	\$3,000
1PK01591	Patel, Suresh / AA Check Cashing	Uninsured Employer	24 month(s) probation		\$0	\$3,000
1JB00964	Perez, Anselmo / A.P.M. Pallet Co.	Uninsured Employer	24 month(s) probation		\$0	\$3,000
0JB10098	Perez, Jose Luis / Perez Wheel & Tire	Uninsured Employer	24 month(s) probation		\$0	\$3,000
BA367430	Perez, Sally / Universal Care Inc.	Claimant Fraud	24 month(s) probation		\$0	\$100
1RI00768	Pham, Hien Thai / Cafe Xing Xinh	Uninsured Employer	24 month(s) probation		\$0	\$2,000
1RI01308	Pham, Joseph / Lien Hoa Choy Restaurant	Uninsured Employer	24 month(s) probation		\$200	\$2,000
BA369626	Plasencia, Diego Steve / Law Offices of Issac E. Guillen	Other	36 month(s) probation 350 hour(s) community service		\$9,000	\$200
BA376217	Ramirez, Christian	Multiple Entities Provider Fraud	24 month(s) prison		\$1,409,909	\$200
BA376217	Ramirez, Hugo	Multiple Entities Provider Fraud	28 month(s) prison		\$1,409,909	\$200
BA376217	Ramirez, Javier	Multiple Entities Provider Fraud	365 day(s) jail 36 month(s) probation		\$1,409,909	\$200
BA366372	Regalado, Baudelio / Snelling Staffing Inc.	Claimant Fraud	2 day(s) jail 36 month(s) probation		\$11,446	\$200

Appendix 3 (continued)
Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Los Angeles County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BA381842	Rosas, Agapito	Claimant Fraud	60 month(s) probation 200 hour(s) community service		\$6,000	\$200
BA355300	Salas, Richard / Public Defender's Office	Claimant Fraud	120 day(s) jail 60 month(s) probation		\$100,000	\$200
BA360611	Saravia, Julio Cesar / Hertz Corp.	Claimant Fraud	1 day(s) jail 60 month(s) probation 200 hour(s) community service		\$6,000	\$200
1AH00635	Sun, Qiang / Tapioca Express	Uninsured Employer	24 month(s) probation		\$0	\$500
1NW01255	Suwansawasdi, Atchara Kongthai / Blue Sand Mind and Body Spa	Uninsured Employer	24 month(s) probation		\$100	\$200
BA369915	Umana, Sandra A. / Jewish Vocational Service	Claimant Fraud	1 day(s) jail 60 month(s) probation 250 hour(s) community service		\$17,995	\$200
BA180434	Urrutia, Christian A.	Claimant Fraud	118 day(s) jail 36 month(s) probation		\$2,908	\$500
BA369529	Valencia-Salgado, Virginia / Ross Stores Inc.	Claimant Fraud	36 month(s) probation		\$0	\$1,000
BA380690	Velasquez, Alfred T.	Claimant Fraud	12 month(s) probation 200 hour(s) community service		\$4,910	\$0
BA379921	Watrin, Michael M. / City of Los Angeles	Claimant Fraud	2 day(s) jail 36 month(s) probation		\$1,130	\$100
BA376308	Yanez, Robert / LAPD	Claimant Fraud	1 day(s) jail 24 month(s) probation 100 hour(s) community service		\$6,234	\$0
1AH00705	Yang, Anson	Uninsured Employer	24 month(s) probation		\$0	\$500
1PK00233	Yousafian, Gary / D'Antonio's Ristorante	Uninsured Employer	24 month(s) probation		\$100	\$3,000

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Marin County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
CR171973	Barajas, Rafael G.	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$500
SC174381	Damato, Jack Joseph / Jd Property Maintenance & Red Rock Const. & Maint.	Uninsured Employer	36 month(s) probation 100 hour(s) community service		\$0	\$10,000
CR171964	Edwins, Charles D.	Claimant Fraud	36 month(s) probation 40 hour(s) community service		\$0	\$500
SC169648	Finau, Siosi / Valeta Construction	Uninsured Employer	12 day(s) jail 36 month(s) probation 50 hour(s) community service		\$0	\$10,000
CR171968	Giammona, Mark A	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$500
SC159710	Gurkovic, Carlton J.	Uninsured Employer	52 month(s) prison		\$28,942	\$0
SC169662	Odiwe, Cleda M / Anton Point	Uninsured Employer	36 month(s) probation 100 hour(s) community service		\$0	\$10,000
CR171965	Ramirez, Jose L.	Uninsured Employer	36 month(s) probation 100 hour(s) community service		\$0	\$500
CR171958	Rojas, Gilberto E.	Uninsured Employer	36 month(s) probation		\$0	\$900
SC168561	Samperio, Josephina / Samperio's Restaurant	Uninsured Employer	20 day(s) jail 36 month(s) probation 100 hour(s) community service		\$0	\$10,000
CR171967	Valazquez, Juan	Uninsured Employer	36 month(s) probation 100 hour(s) community service		\$0	\$500
CR171296	West, Patrick A	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$6,600	\$1,000

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Marin County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
CR171263	Wright, Donald P.	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$500
CR171959	Xec, Juan	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$500

Merced County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
MF49449B	Buendia, Jr., Rudolph / SCIF	Premium Fraud	Six month conditional sentence		\$0	\$0
MF50186	Xavier, Constantino / Dole Foods	Claimant Fraud	36 month(s) probation		\$50,000	\$685

Monterey County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
WCF11-0093	Bonanno, Alfonso / Automotive Specialist	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$170
WCF09-0034	Brunet, Roberta Goulding / Your Home Town Sewing	Claimant Fraud	3 day(s) jail 36 month(s) probation		\$9,451	\$5,190
WCF110059	Carbera, Sebastian Cardenas / Sebastian Gardening & Landscape Services	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,070
WCF10-0083	Celedon, Enrique / California Auto Repair	Uninsured Employer	10 day(s) jail 36 month(s) probation		\$0	\$4,340

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Monterey County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
WCF10-0078	Chaves, Nicholas / Nick's Garage	Uninsured Employer	40 day(s) jail 36 month(s) probation		\$0	\$12,764
WCF11-0087	Cruz, Estaban / Seaside Tire & Rim	Uninsured Employer	30 day(s) jail 36 month(s) probation		\$0	\$2,840
WCF11-0004	Dowling, Joseph Donald / Dowling Custom Iron	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$5,170
WCF11-0048	Furham, Scott / Honest Hauling	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,270
WCF11-0023	Garay, Jesus / Jesus Garay Painting	Uninsured Employer	30 day(s) jail 36 month(s) probation		\$0	\$1,570
WCF11-0033	Garica, Ubaldo Felipe / Ubaldo's Landscape	Uninsured Employer	1 day(s) jail 72 month(s) probation		\$0	\$4,070
WCF11-0050	Gonzalez, Javier / J.G. Handyman Service	Uninsured Employer	1 day(s) jail 72 month(s) probation		\$0	\$3,140
WCF11-0014	Herron, Anthony / Marina Tire And Auto Repair	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$1,660
WCF11-0003	Johnston, James Howard / The Carmel Guild	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,160
WCF11-0005	Leon, Apolina / Soledad Welding And Fabrication	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,060
WCF11-0031	Lopez, Juan Hernandez	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,070
WCF10-0070	Martinez, Vicente / Macs Market	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$5,340
WCF11-0016	Mata, Tony / T&M Fabrication	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,220

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Monterey County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
WCF11-0006	Mora, Jamie / Tri Star Welding	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$1,660
WCF11-0014	Ngo, Danny / Marina Tire & Auto Repair	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$1,660
WCF10-0086	Rendon, Ramon Ray / Rays Auto Car Plus	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$4,340
WCF08-0016	Rodriguez, Absalon / CRS Drywall	Uninsured Employer	120 day(s) jail		\$40,492	\$12,015
WCF11-0058	Sanchez, Fernando	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$1,170
WCF11-0078	Schreiber, Michael / Cal Auto & Tire	Uninsured Employer	5 day(s) jail 36 month(s) probation		\$0	\$3,140
WCF10-0082	Souza, Alfredo / El Tri Auto Repair	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,160
WCF11-0060	Valdez, Alfonso	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$2,170
WCF11-0015	Valencia, Jose Felix / Los Huraches Taquera	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$1,660

Orange County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10CM06359	Ball, Christopher	Uninsured Employer	36 month(s) prison		\$0	\$2,600
09CF1164	Campbell, James Gregory / Democo	Premium Fraud	60 month(s) probation		\$5,832,875	\$200

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Orange County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
09CF2280	Castillo, Reyna Nelly	Claimant Fraud	45 day(s) jail 60 month(s) probation		\$8,000	\$100
09CF3055	Czodor, Tomas	Other	90 day(s) jail 36 month(s) probation		\$0	\$4,500
10CF0850	Denoff, Melissa Robin	Claimant Fraud	2 day(s) jail 36 month(s) probation		\$81,000	\$100
11CM06363	Do, Long Thanh	Uninsured Employer	36 month(s) probation		\$0	\$20,100
10CM06129	Douglas, James Richard	Other	36 month(s) probation 80 hour(s) community service		\$0	\$10,000
06CF0235	Gill, Steven Wayne	Premium Fraud	8 day(s) jail 48 month(s) prison 60 month(s) probation		\$0	\$20,200
10CM06606	Gomez, Manuel Higareda	Uninsured Employer	36 month(s) probation		\$0	\$10,000
08CF0483	Holley, Michael Amzie / So Cal Roofing	Premium Fraud			\$510,884	\$0
11CM06292	Khalil, Abdul / Dollar Mart Plus Market; Bangla Bazar Meat & Produce	Uninsured Employer	36 month(s) probation		\$0	\$10,100
11CM07622	Loucks, Thomas Edward / L & N Movers Inc.	Uninsured Employer	36 month(s) probation		\$0	\$10,100
07CF3781	Mcdonald, Gary Alexander / Gardening Guys	Uninsured Employer	24 month(s) probation		\$20,000	\$100
07CF0244	Mercado, Alejandro	Claimant Fraud	60 month(s) probation		\$39,564	\$200
10CM06479	Mitchell, Mark Corey	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$10,100

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Orange County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
09CF1143	Montes, Rene	Insider Fraud	144 month(s) prison		\$1,776,713	\$200
11CM06363	Nguyen, Mary Chin	Uninsured Employer	36 month(s) probation		\$0	\$20,100
11CM05299	Nguyen, Sherry Lieu	Uninsured Employer	36 month(s) probation		\$0	\$30,000
10CF3318	Sahyoun, George	Uninsured Employer	24 month(s) probation 31 hour(s) community service		\$30,000	\$200

Riverside County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
147889	Barden, Lisa	Claimant Fraud	360 day(s) jail 60 month(s) probation		\$26,999	\$0
1000814	Desai, Rajshekar M / Best Impressions	Uninsured Employer	36 month(s) probation		\$210	\$4,190
1101953	Draney, Rolland / Enterprise Collision Center Inc	Uninsured Employer	36 month(s) probation		\$210	\$3,210
1105299	Flores, Manelito / West Riverside Automotive Repair	Uninsured Employer	36 month(s) probation		\$210	\$2,000
10004261	Friedeck, Alex	Claimant Fraud	36 month(s) probation		\$0	\$0
1103246	Haddad, Yazin / Master Car Care	Uninsured Employer	36 month(s) probation		\$210	\$4,390
1000078	Hamad, Rayan / 99 Cents Mart Plus	Uninsured Employer	36 month(s) probation		\$0	\$4,130

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Riverside County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10013952	Han, Sang Hoon / Natural Curo Clinic	Uninsured Employer	36 month(s) probation		\$210	\$4,390
153274	Hong, Simon Sungheok / Maki Maki Japanese Cuisine	Premium Fraud	24 month(s) prison		\$2,136,816	\$0
10010311	Hu, Jianihua / Eastern Ancient Massage	Uninsured Employer	30 day(s) jail 36 month(s) probation		\$210	\$4,170
1100270	James, Chelsea / Chicago Pizza Company	Claimant Fraud	60 day(s) jail 36 month(s) probation		\$11,387	\$0
1106524	Jung, Il / Kawa Day Spa	Uninsured Employer	36 month(s) probation		\$210	\$10,000
10005083	Kim, Suyon / Sun Acupuncture	Uninsured Employer	97 day(s) jail 36 month(s) probation		\$0	\$0
029583	Kizziar, Caryn Nora / Citywide Roofing	Premium Fraud	180 day(s) jail 36 month(s) probation		\$768,996	\$0
029583	Kizziar, Dale Warren / Citywide Roofing	Premium Fraud	180 day(s) jail 36 month(s) probation		\$768,996	\$0
1102212	Lee, John / Riverwalk Massage Spa	Uninsured Employer	36 month(s) probation		\$210	\$4,390
2111318	Leon, Erasmo / El Ruben Tacos #3	Uninsured Employer	36 month(s) probation		\$125	\$4,130
10008148	Li, Mengnan / Crystal Spa	Uninsured Employer	36 month(s) probation		\$210	\$4,130
10008409	Lin, Hsin / Pacific Massage	Uninsured Employer	36 month(s) probation		\$210	\$4,130
10002318	Maris, Gyongi / The Corner Pocket	Uninsured Employer	36 month(s) probation		\$210	\$4,130

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Riverside County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10000069	Mosby, Jacques	Claimant Fraud	60 day(s) jail 36 month(s) probation		\$11,700	\$0
1103212	Moxley, Timothy / Body Works	Uninsured Employer	36 month(s) probation		\$210	\$4,390
10011879	Moxley, Timothy / Body Work Massage	Uninsured Employer	36 month(s) probation		\$210	\$4,390
10005528	Murillo, Encar Cuenca / Filipino Asian Market	Uninsured Employer	36 month(s) probation		\$0	\$4,130
542931	Nguyen, Cuc Kim Thi / Fresh Drinking Water	Uninsured Employer	36 month(s) probation		\$210	\$2,130
10008149	Ni, Yapin / Breeze Harbor Massage Spa	Uninsured Employer	36 month(s) probation		\$210	\$4,130
10011314	Oh, Angela / Best Acupuncture	Uninsured Employer	36 month(s) probation		\$0	\$610
10016461	Oh, Chang / J Acupuncture	Uninsured Employer	30 day(s) jail 36 month(s) probation		\$210	\$2,180
10013610	Ok, Sung Hiup / Bee Acupuncture	Uninsured Employer	30 day(s) jail 36 month(s) probation		\$0	\$2,065
153274	Shinn, Katie Kyanghee / Maki Maki Japanese Cuisine	Premium Fraud	48 month(s) prison		\$2,136,816	\$0
10006787	Shon, Phillip / Phillip Acupuncture	Uninsured Employer	45 day(s) jail 36 month(s) probation		\$210	\$8,390
1102747	Tu, Tony / D H Massage	Uninsured Employer	36 month(s) probation		\$210	\$1,000
10013247	Villasenor, Mayte Catalan / Magic Touch Massage	Uninsured Employer	3 day(s) jail 36 month(s) probation		\$125	\$4,130

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Riverside County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10011936	Villasenor, Mayte Catalan / Truly Madly Sweetly	Uninsured Employer	3 day(s) jail 36 month(s) probation		\$125	\$4,130
1100926	Young, Lourdes / Brooke Insurance Services	Insider Fraud	179 day(s) jail 36 month(s) probation		\$0	\$0
10008411	Zhang, Liang / Oriental Health	Uninsured Employer	36 month(s) probation		\$0	\$610
10009227	Zhang, Yi Bing / Wild Card Gaming	Uninsured Employer	36 month(s) probation		\$210	\$4,030
1100875	Zhou, Yan / Beijing Wok Chinese Fast Food	Uninsured Employer	36 month(s) probation		\$210	\$3,390

Sacramento County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
11M02404	Archuleta, Max / Image Lounge	Uninsured Employer	24 month(s) probation		\$1,840	\$1,315
10F04743	Blackburn, John Dravo	Insider Fraud	30 day(s) jail 36 month(s) probation		\$214	\$100
09F07049	Cho, Kil Myoung / Newbold Cleaners	Other	36 month(s) probation		\$15,000	\$100
09F07049	Cho, Shaun Jung / Newbold Cleaners	Other	36 month(s) probation		\$0	\$100
08F09967	Currier, Robert Edward	Claimant Fraud	174 hour(s) community service		\$0	\$100
11F02661	Diaz, Marie Yvonne	Claimant Fraud	20 day(s) jail 36 month(s) probation		\$1,293	\$100

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Sacramento County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10F02849	Enriquez, Juan Artega / Juan's Roofing	Premium Fraud	120 day(s) jail 60 month(s) probation		\$17,108	\$200
10M00245	Esparza, Alma Delia / Azukar Rest. & Lounge	Uninsured Employer	36 month(s) probation		\$3,730	\$100
10M05256	Kim, Ki Yeol / Crazy Sushi	Uninsured Employer	36 month(s) probation		\$0	\$2,855
11F00151	Lane, Bobby Ray	Claimant Fraud	45 day(s) jail		\$6,298	\$100
10F07363	Pamma, Amarjit Singh / Millennium Farms	Premium Fraud	1 day(s) jail 36 month(s) probation		\$35,000	\$0
10M00245	Pham, Al Minh / Azukar Rest. & Lounge	Uninsured Employer	36 month(s) probation		\$3,730	\$100
10M00245	Pham, Tam Minh / Azukar Rest. & Lounge	Uninsured Employer	36 month(s) probation		\$3,730	\$100
11M02424	Ponce, Andrew Conrad / Stampede Concrete	Uninsured Employer	36 month(s) probation		\$100	\$890
10F06394	Reading, Christopher Martin	Claimant Fraud	36 month(s) probation 420 hour(s) community service		\$7,054	\$200
11F02659	Schneider, Eric Robert / CM Builders, Inc.	Premium Fraud	90 day(s) jail 60 month(s) probation		\$50,394	\$400
11M02404	Shaffer, Eric Scott / Image Lounge	Uninsured Employer	24 month(s) probation		\$1,840	\$1,315
09F04731	Tarantino, Cheryl Lynn / Meineke Car Care Service	Premium Fraud	36 month(s) probation		\$0	\$1,045
08F07878	Valenzuela, Victor Daniel	Premium Fraud	180 day(s) jail 60 month(s) probation		\$174,424	\$200

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Sacramento County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
11M00217	Wagner, David Sean	Uninsured Employer	12 month(s) probation		\$0	\$640
11M02404	Wright, Clifford Todd / Image Lounge	Uninsured Employer	24 month(s) probation		\$0	\$1,450

San Bernardino County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
MSB1003619	Agleh, David / Yucaipa Tire Store	Uninsured Employer	24 month(s) probation		\$0	\$2,170
MVA1001110	Benitez, Maria / Belos Appliance	Uninsured Employer			\$0	\$465
FSB900064	Chapman, Karen	Claimant Fraud	1 day(s) jail 60 month(s) probation 200 hour(s) community service		\$14,776	\$0
MWV1001922	Cordova, Alfonso / Cordova Tires	Uninsured Employer	12 month(s) probation		\$0	\$1,110
MWV1001647	Davoudi, Rafia / Advanced Alternator	Uninsured Employer	2 day(s) jail 36 month(s) probation 40 hour(s) community service		\$0	\$10,110
FSB1000709	Dodson, Storyan	Claimant Fraud			\$30,000	\$0
MVI1000777	Fleming, Carolyn / R&R Tires	Uninsured Employer	24 month(s) probation		\$0	\$1,610
MWV1002889	Francis, Marvin / Francis Chiropractic	Uninsured Employer	24 month(s) probation		\$0	\$2,000
MSB1003656	Good, Ralph / Ralphs Custom Cabinets	Uninsured Employer	36 month(s) probation		\$0	\$3,110

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Bernardino County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
FWV1002975	Goodman, Billy	Claimant Fraud	9 day(s) jail 36 month(s) probation		\$6,400	\$270
MWV1101644	Heang, Ny / DN Top Donuts	Uninsured Employer	36 month(s) probation		\$0	\$2,380
MSB1003605	Hernandez, Robert / El Sombrero Banquet	Claimant Fraud			\$0	\$1,000
MSB1001813	Huda, Khaled / K&B Auto Body Repair	Uninsured Employer			\$0	\$5,110
MBA1000284	Kamel, Saed / Swiss Dairy & Liquor	Uninsured Employer			\$0	\$602
MWV1100938	Karapetian, Rina / Safari Insurance Services	Uninsured Employer	24 month(s) probation		\$0	\$1,110
MVA1001150	Ledesma, Jose / Rialto Tires/Ledesma Auto	Uninsured Employer	33 month(s) probation 20 hour(s) community service		\$0	\$5,110
FSB703748	Mendoza, Beatriz / Target Construction	Premium Fraud	120 day(s) jail 60 month(s) probation		\$683,553	\$400
FSB703748	Mendoza, Daniel / Target Construction	Premium Fraud	120 day(s) jail 60 month(s) probation		\$683,553	\$400
MSB1001571	Morad, Ebrahim / Dynamic Auto	Uninsured Employer	36 month(s) probation		\$0	\$3,199
MSB1002571	Morales, Walter / Morales Tires	Claimant Fraud	36 month(s) probation 40 hour(s) community service		\$0	\$3,000
MWV1004665	Nawid, Ahmad / Fairuz Market	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$5,110
MSB100801	Noriega, Baltazar / Cool Water #2	Uninsured Employer	36 month(s) probation 30 hour(s) community service		\$0	\$1,110

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Bernardino County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
FWV901432	Offerman, Arno	Claimant Fraud	180 day(s) jail		\$0	\$0
MWV1000530	Olivares, Ignacious / Antojitos Gentrys Restaurant	Uninsured Employer	24 month(s) probation		\$0	\$1,110
MVA1100571	Ortiz, Mariano / Twl Tire Center	Uninsured Employer	36 month(s) probation		\$0	\$2,000
MVI1003334	Parker, Barbara / Auction City	Uninsured Employer			\$0	\$500
FSB702337	Peace, Sheri	Claimant Fraud	230 day(s) jail 2 month(s) probation		\$0	\$0
MVI1003637	Perez, Julie	Other	24 month(s) probation		\$0	\$180
FVI1001978	Piper-Morris, Brenda	Other	32 month(s) prison		\$3,617	\$200
MVA1001121	Ramirez, Francisco / Ramirez Upholstery	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$1,110
FSB1004810	Rocha, Raul / R&R Roofing	Premium Fraud	1 day(s) jail 36 month(s) probation		\$0	\$0
MVA1001124	Ruiz, Aurelio / King Tire Service	Uninsured Employer	36 month(s) probation		\$0	\$3,600
MSB1002250	Saleh, Dib / Sun Automotive Repair	Uninsured Employer	24 month(s) probation		\$0	\$2,000
MWV905572	Sarafin, Dory / Precision Custom Conversions	Uninsured Employer	24 month(s) probation		\$0	\$2,110
MVA1001115	Shakespeare, Doris / Shakespeare Motors	Uninsured Employer	36 month(s) probation		\$0	\$1,110

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Bernardino County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
FWV801235	Shriver, Steve	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$39,310	\$200
MWV1002533	Spina, Donna / DJS Lounge	Uninsured Employer	24 month(s) probation		\$0	\$2,110
MSB1000006	Trujillo, Hector / H&R Smog Check	Uninsured Employer	24 month(s) probation		\$0	\$1,110
MVA1100765	Ureta, Candido / Candy Man Cynlinder And Head Repair	Uninsured Employer	24 month(s) probation		\$0	\$2,180
FVI1002012	Ursua, Rudy	Claimant Fraud	180 day(s) jail 48 month(s) probation		\$15,534	\$110
MCH1000436	Venugopal, Mathavan / Wally's Radiator	Uninsured Employer	36 month(s) probation 80 hour(s) community service		\$0	\$3,110
MSB903564	Washington, Jeanne / It Figures	Uninsured Employer	24 month(s) probation 40 hour(s) community service		\$0	\$170

San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C310856	Alfaro, Jose Alfred	Uninsured Employer	36 month(s) probation		\$0	\$250
M094507	Alvarez, Ricardo	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$2,000	\$100
M075533	American Exchange Inc	Uninsured Employer	36 month(s) probation		\$5,000	\$465
C310733	Anderson, Elias Paul Berkshire	Uninsured Employer	36 month(s) probation		\$0	\$250

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
CD226514	Audelo, Anita	Multiple Entities Provider Fraud	36 month(s) probation		\$0	\$0
C310857	Ayon, Leonardo Sanchez	Uninsured Employer	36 month(s) probation		\$0	\$250
M094249	Aztec Tan Inc.	Uninsured Employer	36 month(s) probation		\$500	\$130
ACY083	Baker, Christine	Claimant Fraud	1 day(s) jail 36 month(s) probation 200 hour(s) community service		\$51,482	\$800
M094459	Berkes , Jaime Nicole / Jaime Nicole International	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$500	\$130
C306711	Bernal, Armando	Uninsured Employer	36 month(s) probation		\$0	\$500
C310747	Briese, Chad Anthony	Uninsured Employer	36 month(s) probation		\$0	\$0
M094463	Bright, Duntae	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$225
M094508	Buirds, Brian / Phileas Foggs Inc	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$2,000	\$100
M092688	Buki, Attila	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,000	\$0
M094447	Cabo, Daniel / La Jolla Star Transportation Inc	Uninsured Employer			\$0	\$217
ACS156	Candela, Arturo	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$11,459	\$800
ACR918	Cannon, Daniel Joseph	Premium Fraud	1 day(s) jail 36 month(s) probation		\$194,541	\$0

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C310736	Castellanos, Dennis Orlando	Uninsured Employer	36 month(s) probation		\$0	\$500
M085473	Cazares, Ruben	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$6,500	\$150
ACX905	Cepeda, Juan Guada	Claimant Fraud	20 day(s) jail 36 month(s) probation		\$0	\$0
C310745	Chavez, Joel Jimenez	Uninsured Employer	36 month(s) probation		\$0	\$500
M065255	Coast Courier Llc	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$10,000	\$130
M094548	Colak, Nazim	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$1,500	\$100
C310731	Cordova, Roberto	Uninsured Employer	36 month(s) probation		\$0	\$500
M094462	Craftsmen Steel Buildings Inc	Uninsured Employer	36 month(s) probation		\$0	\$130
M094510	Cuevas, Frank	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$7,000	\$100
M094247	Daoud, Nadhal Salim	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$2,000	\$130
M094547	Delarosa, Florentino	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$1,000	\$0
M094532	Denobrega, Agostinho	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$500	\$100
M031110	Do, Hai Van	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,000	\$225

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C310746	Dominguez, Cesar Joaquin	Uninsured Employer	36 month(s) probation		\$0	\$250
M094532	Dowerglen Enterprises, Inc.	Uninsured Employer	36 month(s) probation		\$0	\$0
M094505	Duenas, Jose Louis	Uninsured Employer	1 day(s) jail 36 month(s) prison		\$1,500	\$0
ACS100	Dunn, Christine Marie	Claimant Fraud	36 month(s) probation		\$100	\$200
M094143	Ellis, Ian Oneil	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$1,000	\$130
M094277	Empire Corporation	Uninsured Employer			\$5,000	\$130
M094557	Feliccia, Salvatore	Uninsured Employer	36 month(s) probation		\$2,000	\$100
ACR420	Ferrer, Maricel	Claimant Fraud	1 day(s) jail 60 month(s) probation 160 hour(s) community service		\$29,947	\$0
M094508	Foggs Inc., Phileas	Uninsured Employer	36 month(s) probation		\$2,000	\$100
ACS047	Foreman, Barbara Jean	Claimant Fraud	120 day(s) jail 36 month(s) probation 100 hour(s) community service		\$15,200	\$800
M090454	Garcia, Ivett Lopez	Uninsured Employer	36 month(s) probation		\$3,000	\$100
ACR598	Gibson, Zachary West	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$25,051	\$400
M094527	Gonzalez, Francisco	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$5,000	\$240

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
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San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
M094464	Gonzalez, Pablo R	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$6,000	\$200
M094536	Ha, Tien Van	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,500	\$100
M092684	Heller, Areeanne Anne	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$2,500	\$130
M094542	Herbert, Karen Lynn	Uninsured Employer	36 month(s) probation		\$1,000	\$100
M065255	Herscovici, Monel / Coast Courier Llc	Uninsured Employer	36 month(s) probation		\$0	\$235
M094233	Hilgers Holdings 64, Inc.	Uninsured Employer	36 month(s) probation		\$10,000	\$130
M094233	Hilgers, Lester Leroy / Hilgers Holdings 64, Inc.	Uninsured Employer			\$0	\$257
C306713	Hollister, Thomas	Other	36 month(s) probation		\$0	\$250
M094462	Houston, Randall James / Craftsmen Steel Buildings, Inc.	Uninsured Employer	36 month(s) probation		\$0	\$130
M094447	Hutter, Franz / La Jolla Star Transportation Inc	Uninsured Employer			\$0	\$217
C306715	Ibarra, Rafael	Uninsured Employer			\$0	\$700
ACR795	Idemoto, Roger Ken	Premium Fraud			\$25,000	\$0
M094459	Jaime Nicole International	Uninsured Employer	36 month(s) probation		\$10,000	\$130

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
ACR974	James, Bonnie	Premium Fraud	365 day(s) jail 36 month(s) probation		\$0	\$0
M094236	James, William Harold	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$947	\$130
C310791	Jimenez, Santiago Huante	Claimant Fraud	36 month(s) probation		\$0	\$250
M094519	Jocson, Wilfredo De Castro	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$1,500	\$260
CD226514	Kady, Mohamed T	Multiple Entities Provider Fraud	36 month(s) probation	\$225,000	\$195,000	\$0
MAT917	Kurtenbach, James Anthony	Premium Fraud	111 month(s) prison		\$0	\$0
M094447	La Jolla Star Transportation Inc	Uninsured Employer	36 month(s) probation		\$4,000	\$130
CN283638	Labayen, Mila	Uninsured Employer			\$0	\$0
ACR809	Landers, Susan	Premium Fraud	1 day(s) jail 36 month(s) probation		\$60,672	\$0
ACS127	Lazo, Panfilo	Claimant Fraud	90 day(s) jail 36 month(s) probation		\$9,999	\$0
M094454	Leahy, Sean Patrick	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,500	\$130
ACR756	Lemler, Lawrence	Claimant Fraud	1 day(s) jail 36 month(s) probation	\$355,350	\$827,038	\$0
M094235	Liang, Wei Chang	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$8,500	\$130

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
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San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
M094515	Lisa'S Dessert, Inc	Uninsured Employer	36 month(s) probation		\$0	\$278
M094467	Logan, Barry Allen	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$4,000	\$0
ACR974	Loper, James Alden	Premium Fraud	72 month(s) prison		\$390,981	\$0
M094487	Lopez, Frank	Premium Fraud	1 day(s) jail 36 month(s) probation 120 hour(s) community service		\$12,000	\$130
M094487	Lopez, Mary Atocha	Premium Fraud	1 day(s) jail 36 month(s) probation 120 hour(s) community service		\$12,000	\$130
M094541	Lu, Luong Boa	Uninsured Employer	36 month(s) probation		\$2,500	\$100
ACR342	Lutero, Joseph Valencia	Claimant Fraud	1 day(s) jail 36 month(s) probation		\$2,139	\$0
M094549	Manion, Neal	Uninsured Employer	36 month(s) probation		\$2,500	\$120
M094520	Maroki, Essim	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$5,000	\$0
ACU223	Mehling, Randy Dean	Claimant Fraud	181 day(s) jail 36 month(s) probation		\$76,049	\$800
C306716	Mendez, David	Uninsured Employer	36 month(s) probation		\$1,000	\$800
ACR928	Molano, Eugenio	Claimant Fraud	180 day(s) jail 36 month(s) probation		\$200	\$0
M094539	Morales, Gilberto	Uninsured Employer	36 month(s) probation		\$2,000	\$0

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
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San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
M094468	Moshe, Raed	Uninsured Employer	36 month(s) probation		\$3,500	\$10,130
C310855	Motas Jr, Gregory Allen	Uninsured Employer	36 month(s) probation		\$0	\$500
M094536	Nguyen, Nghi Thanh	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$500	\$0
M094257	Niems, Craig A	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$4,000	\$257
C310856	Norcross, Michael Anthony	Uninsured Employer	36 month(s) probation		\$0	\$250
ACR131	Olsen, Bobby	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$6,318	\$0
M094274	Pacific Suites, Inc.	Uninsured Employer	36 month(s) probation		\$0	\$130
M075536	Panahi, Hamed Reza	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$6,000	\$120
M094514	Partners, Vista Pub	Uninsured Employer	36 month(s) probation		\$12,000	\$10,000
M094533	Paschalydis, Laurie	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,000	\$100
M094277	Peterson, John Ray / Empire Corporation	Uninsured Employer			\$5,000	\$10,000
M094528	Plascencia, Roberto	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,500	\$10,000
M094461	Ponto, Judy Ann	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$20,000	\$130

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
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San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
M094461	Ponto, William Harry	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$20,000	\$130
C310737	Reyes, Abraham Zafra	Uninsured Employer	36 month(s) probation		\$0	\$250
M094515	Rivera, Ana Lisa / Lisa's Dessert, Inc	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$10,000	\$278
M094515	Rivera, Eduardo / Lisa's Dessert, Inc	Uninsured Employer	2 day(s) jail 36 month(s) probation		\$0	\$278
ACR876	Rivera, Jose Armando	Claimant Fraud	25 day(s) jail 36 month(s) probation		\$0	\$200
ACX612	Rodriguez, Rosa	Claimant Fraud	19 day(s) jail 36 month(s) probation		\$0	\$100
ACR877	Sanchez, Mario	Claimant Fraud	90 day(s) jail 36 month(s) probation		\$10,000	\$200
M094257	Sans, Inc	Uninsured Employer	36 month(s) probation		\$4,000	\$130
ACR724	Scaccia, Nancy Ann	Claimant Fraud			\$6,937	\$0
ACL977	Shekell, Jeffrey A	Premium Fraud	115 day(s) jail 36 month(s) probation		\$19,857	\$0
ACL416	Song, Hun Geun	Premium Fraud	1 day(s) jail 36 month(s) probation		\$200,000	\$0
ACS208	Stovall, Mamie	Claimant Fraud	36 month(s) probation		\$7,600	\$0
M094539	Super Shops, Racing	Uninsured Employer	36 month(s) probation		\$0	\$0

Appendix 3 (continued)
Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

San Diego County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
M094514	Tardy, Leroy / Vista Pub Partners	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$12,000	\$10,000
ACR940	Thomas, Vicky Louise	Claimant Fraud	1 day(s) jail 36 month(s) probation 150 hour(s) community service		\$2,500	\$800
M094536	Ton, Mong Thao	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$2,500	\$100
M094536	Tran, Jenny	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$500	\$100
M094465	Tsui, Connie	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$2,000	\$130
M094249	Vazquez, Jason	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$500	\$217
M094063	Velazquez, Jesus	Uninsured Employer	36 month(s) probation		\$0	\$300
ACR529	Vidaurreta, Frank Manuel	Claimant Fraud	28 day(s) jail 36 month(s) probation		\$0	\$0
M094466	Votel, Ralph Douglas	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$1,500	\$130
M072648	Walker, Clinton Colin	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$1,000	\$10,000
M094511	Walker, Matthew Michael	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$1,500	\$475
M094504	Weinzimer, Kristy / Who Invited You Inc	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$3,000	\$100
M094504	Weinzimer, Robert / Who Invited You Inc	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$100
M094504	Who Invited You Inc.	Uninsured Employer	36 month(s) probation		\$0	\$100

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
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San Francisco County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
20090404	Bassam, Shamiya	Uninsured Employer			\$0	\$1,000
11006549	Coral, Leticia	Insider Fraud	364 day(s) jail 36 month(s) probation		\$0	\$405
2427318	Guzman, Kivin Lara	Claimant Fraud	36 month(s) probation		\$24,073	\$140
11006891	Hegner, Emily	Claimant Fraud	36 month(s) probation 720 hour(s) community service		\$49,860	\$515
20090593	Leung, Yui Kee	Uninsured Employer			\$0	\$1,000
20090544	Sater, Lynn	Insider Fraud	270 day(s) jail 60 month(s) probation 880 hour(s) community service		\$46,000	\$0
10011927	Shin, Sam	Premium Fraud	364 day(s) jail 60 month(s) probation		\$111,357	\$0

San Joaquin County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
SF115519A	Alonzo, Carolina C. / Adecco	Claimant Fraud	30 day(s) jail 60 month(s) probation		\$13,320	\$220
SF116116B	Carver, Carolyn E / Sheet Metal Workers	Claimant Fraud	60 month(s) probation		\$324	\$220
SF116116C	Carver, Sean Ryan / Sheet Metal Workers	Claimant Fraud	1 day(s) jail 60 month(s) probation		\$0	\$220
SF105259A	Gallardo, Sergio Raul	Claimant Fraud	30 day(s) jail 60 month(s) probation		\$10,000	\$220

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****San Joaquin County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
SF113906A	Mejia, Guadalupe Linan / National Security Industries	Claimant Fraud	60 month(s) probation		\$3,000	\$220
SF096395A	Moran, Alfred Herbert / Hamco Services Group	Claimant Fraud	90 day(s) jail 60 month(s) probation		\$673,239	\$220
SF113025A	Nguyen, Sang Jason / Nationwide Insurance	Insider Fraud	30 day(s) jail 60 month(s) probation		\$25,566	\$220
SF103147A	Ourganjian, Marcia / O'Connor Woods	Claimant Fraud	36 month(s) probation		\$7,353	\$110
SF106604C	Sang, Brookes Juk Hung / Mallards Restaurant	Uninsured Employer	48 month(s) probation		\$365,000	\$220
SF106604B	Sang, Richard Juk Kuie / Mallards Restaurant	Uninsured Employer	48 month(s) probation		\$365,000	\$220
SF106604A	Sang, Richard Wun Ping / Mallards Restaurant	Uninsured Employer	24 month(s) prison 36 month(s) probation		\$365,000	\$220
SF109901A	Smith, Brenda / Icap World Services	Claimant Fraud	36 month(s) probation		\$3,795	\$110
SF113924A	St. John, Tracy Elisabeth / Raley's	Claimant Fraud	36 month(s) probation		\$29,400	\$110
SF116116A	Weil, Brandon William / Sheet Metal Workers	Claimant Fraud	60 month(s) probation		\$3,680	\$220

San Mateo County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
SF369253	Delrosario, Anthony/Bi Rite	Claimant Fraud	1 day(s) jail 24 month(s) probation		\$8,800	\$170

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

San Mateo County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
SC071615	Gomez, Margarita /Seton Hospital	Claimant Fraud	180 day(s) jail 36 month(s) probation		\$64,603	\$340
SF369270	Ludlow, Christopher / Boudreau Plumbing	Claimant Fraud	24 month(s) probation		\$15,000	\$170
NF399454	Maciel, Ignacio / Nordstrom	Claimant Fraud	30 day(s) jail 24 month(s) probation		\$974	\$180
NM391737	Melkonian, Mike	Uninsured Employer	24 month(s) probation		\$0	\$870
SC071228A	Mentch, Stefanie Annaliisa	Claimant Fraud	45 day(s) jail 36 month(s) probation		\$4,980	\$260
SF364351	Rita, Antone / Menlo Park	Claimant Fraud	30 day(s) jail 36 month(s) probation		\$20,198	\$170
SC070989	Rivera- Santos, Aron	Claimant Fraud	30 day(s) jail 36 month(s) probation		\$9,350	\$160
SC072504	Vasquez, Mathilde Reynaldo / San Mateo County	Claimant Fraud	45 day(s) jail 36 month(s) probation		\$25,199	\$270

Santa Barbara County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
1333502	Campos, Maria Elena / The Zia Cafe	Uninsured Employer	36 month(s) probation		\$0	\$513
1333503	Chen, David / Red Pepper Chinese Restaurant	Uninsured Employer	36 month(s) probation		\$0	\$12,715
1347382	Kennedy, Steven / Self	Uninsured Employer	36 month(s) probation		\$0	\$10,000

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Santa Barbara County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
13536165	Martinez, Abel / Soteris Trucking	Uninsured Employer	1 day(s) jail 36 month(s) probation		\$0	\$0
1347380	Monroy, Richard / Self	Uninsured Employer	36 month(s) probation		\$0	\$10,125
1333501	Morin, Yzan M / Pacific Crepes Cafe	Uninsured Employer	36 month(s) probation		\$0	\$10,000
1333500	Promsupsin, Narong / Bangkok Palace Restaurant	Uninsured Employer	36 month(s) probation		\$0	\$14,698
1347381	Sullivan, Shaun Patrick / Self	Uninsured Employer	36 month(s) probation		\$0	\$0
1347379	Wisler, Jeffrey / Self	Uninsured Employer	36 month(s) probation		\$0	\$10,155

Santa Clara County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C1072714	Athans, Angelo / Office Solutions Interiors	Premium Fraud	90 day(s) jail 36 month(s) probation		\$90,085	\$200
C1198668	Bustamonte, Raymond Valentino / Rm Construction	Uninsured Employer			\$0	\$110
C1067951	Calzada, Norma / Beverly Hills Diagnostic Medical Group	Single Entity Provider Fraud	4 day(s) jail 24 month(s) probation		\$0	\$110
C1073731	Campbell, Bruce / Posh Bagel	Premium Fraud	180 day(s) jail 36 month(s) probation		\$0	\$0

Appendix 3 (continued)
Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011
Santa Clara County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C1072597	Chan, Jessica	Claimant Fraud	150 day(s) jail 60 month(s) probation		\$39,840	\$220
C1076664	Chikayasu, Barry	Claimant Fraud	90 day(s) jail 36 month(s) probation		\$19,044	\$220
C1070963	Cool, Philip / Cool's Custom Tile & Mosaic	Premium Fraud	90 day(s) jail 36 month(s) probation		\$20,482	\$110
C1068488	Del Rosario, Gerry	Claimant Fraud	30 day(s) jail 24 month(s) probation		\$9,882	\$110
C1077249	Garcia, Lorenzo Ramirez	Uninsured Employer	24 month(s) probation		\$0	\$110
C1093774	Ge, Robert / Robert Ge Construction	Uninsured Employer			\$0	\$100
CC960364	Gonzalez, Raul / San Andreas HVAC	Premium Fraud	120 day(s) jail 36 month(s) probation		\$0	\$100
C1196607	Guerrero, Eduardo / Evergreen Valley Landscaping	Uninsured Employer	12 month(s) probation		\$0	\$110
CC940162	Haas, Ronald / Rj Haas Construction	Premium Fraud	365 day(s) jail 36 month(s) probation		\$1,609,729	\$2,000
F1033945	Hawkins, Justin	Uninsured Employer	3 month(s) probation		\$0	\$110
C1083615	Hernandez, Casimiro / Royal Cleaners	Uninsured Employer	12 month(s) probation		\$0	\$110
C1073715	Hudson, John	Claimant Fraud	120 day(s) jail 24 month(s) probation		\$0	\$110
C1198690	Huizar, Luis Miguelalaniz / Alaniz Construction	Uninsured Employer	12 month(s) probation		\$0	\$110

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Santa Clara County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C1072686	Ko, Yong Chun	Uninsured Employer	24 month(s) probation		\$0	\$110
C1073157	Kuang, Jack	Claimant Fraud	182 day(s) jail 60 month(s) probation		\$39,700	\$220
C1095139	Le, David	Uninsured Employer	24 month(s) probation		\$0	\$110
C1073731	Lee, Cheryl Ann / Posh Bagel	Premium Fraud	100 hour(s) community service		\$0	\$0
C1095366	Lipscomb, Clinton / Cool Looking Concrete	Uninsured Employer			\$0	\$110
F1033946	Lopez, Carmelo	Uninsured Employer			\$0	\$110
C1084182	Maro, Dean Arthur / Pipelyne Manufacturing	Uninsured Employer	12 month(s) probation		\$0	\$110
C1072489	Martines, Pedro / Valdovinos	Claimant Fraud	365 day(s) jail 12 month(s) probation		\$7,473	\$220
C1100409	Martinez, Isacc Miguel / Bay To Bay Concrete	Uninsured Employer	60 month(s) probation		\$40,000	\$110
C1073424	Miranda, Rommel	Claimant Fraud	182 day(s) jail 60 month(s) probation		\$4,367	\$200
C1073626	Nelson, Daniel / Worldwide Attractions	Premium Fraud	120 day(s) jail 36 month(s) probation		\$55,000	\$220
C1087091	Nicolas, Roger Georges	Uninsured Employer	12 month(s) probation		\$0	\$110
C1073731	Ottoveggio, Jeffrey / Posh Bagel	Premium Fraud	180 day(s) jail 36 month(s) probation		\$698,581	\$220

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Santa Clara County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
C1104455	Padilla, Jesus / JPL	Uninsured Employer	1 day(s) jail 1 month(s) probation		\$0	\$110
CC960364	Ramos, Carlos / San Andreas HVAC	Premium Fraud	120 day(s) jail 36 month(s) probation		\$204,421	\$200
CC960364	Ramos, Ramiro / San Andreas HVAC	Premium Fraud	120 day(s) jail 36 month(s) probation		\$0	\$100
F1033573	Ross, Paul	Uninsured Employer	4 day(s) jail 36 month(s) probation		\$0	\$220
CC960364	Salas, Antonio / San Andreas HVAC	Premium Fraud	120 day(s) jail 36 month(s) probation		\$0	\$100
C1091782	Svoboda, Radek	Uninsured Employer	2 month(s) probation		\$0	\$380
C1095211	Tran, Hon Van / Hon's Auto Repair	Uninsured Employer	24 month(s) probation		\$0	\$180
C1066705	Turner, Emily	Claimant Fraud	60 day(s) jail 60 month(s) probation		\$11,088	\$220
C1083743	Wi, Jung Hoon / JS Motors	Uninsured Employer	24 month(s) probation		\$0	\$110
C1091141	Zhu, Zheng Gen / Z&Y Construction	Uninsured Employer			\$0	\$110

Santa Cruz County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
F18568	Lee, Teresa	Claimant Fraud			\$39,000	\$490
f17423	Mendez, Blanca	Claimant Fraud			\$440	\$0

Appendix 3 (continued)**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011****Shasta County**

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10WC0505	Albion, Joseph Anthony	Uninsured Employer	36 month(s) probation		\$0	\$0
10WC0702	John, Barney Nmn	Uninsured Employer	36 month(s) probation		\$0	\$0
09WC0114	Lembo, George Michael	Uninsured Employer	36 month(s) probation		\$250	\$360
10WC0646	Martin, Dean Paul	Uninsured Employer	36 month(s) prison		\$0	\$0
10WC0538	Perry, Thomas Otis	Uninsured Employer	36 month(s) probation		\$0	\$0

Sonoma County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
SCR497568	Lemus-Guzman Francisco / Madrona Manor	Claimant Fraud	120 day(s) jail 36 month(s) probation		\$12,707	\$0

Tehama County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
BI10-811	James L. Wooten	Uninsured Employer	18 month(s) probation		\$100	\$473
BI10-863	Dennis A. Williams Jr.	Uninsured Employer	18 month(s) probation		\$100	\$870

Appendix 3 (continued)

**Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011**

Tulare County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
09014127	Aguilar, Maria	Uninsured Employer	36 month(s) probation 60 hour(s) community service		\$0	\$180
10018492	Blackmon, Gregg	Uninsured Employer	36 month(s) probation		\$0	\$2,250
201014832	Cabrera, Mark	Uninsured Employer	36 month(s) probation		\$0	\$5,150
10012437	Cunningham, Michael	Uninsured Employer	12 month(s) probation		\$0	\$4,040
VCM206415	Diaz, Jorge / A.P. Bookkeeping	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$0	\$5,540
11-003386	Escamilla, Antonio	Uninsured Employer	36 month(s) probation		\$0	\$1,600
11-006203	Estrada, Ramon	Uninsured Employer	36 month(s) probation		\$0	\$2,540
10005790	French, Steve	Uninsured Employer	36 month(s) probation		\$0	\$3,440
VCM206415	Gutierrez, Margarita / A.P. Bookkeeping	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$0	\$10,540
10018492	Johnson, Arlon	Uninsured Employer			\$0	\$10,685
09FW026547	Kendall, Jeffrey	Uninsured Employer	36 month(s) probation		\$0	\$3,270
11-003280	Limas, Ezequiel	Uninsured Employer	36 month(s) probation		\$0	\$1,600

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Tulare County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
VCM206415	Nunez, Hector / A.P. Bookkeeping	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$0	\$16,040
VCM206415	Padilla, J.L. / A. P. Bookkeeping	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$2,968	\$7,540
VCM206415	Parlan, Dinah / A. P. Bookkeeping	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$0	\$15,040
09023567	Parlan, Dinah / Golden Grain	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$0	\$15,040
201014841	Russo, Anthony	Uninsured Employer	3 day(s) jail 36 month(s) probation		\$0	\$320
10019132	Sanchez, Daniel	Uninsured Employer	36 month(s) probation 40 hour(s) community service		\$0	\$840
201014833	Sanchez, George	Uninsured Employer	24 month(s) probation 40 hour(s) community service		\$0	\$180
10005867	Springs, Richard	Uninsured Employer	36 month(s) probation		\$0	\$1,670
10018488	Sweedon, Dennis	Uninsured Employer	24 month(s) probation 60 hour(s) community service		\$0	\$1,750
10018491	Turner, Jeffrey	Uninsured Employer	24 month(s) probation		\$0	\$1,540
VCM206415	Veloria, Daniel / A.P. Bookkeeping	Premium Fraud	180 day(s) jail 36 month(s) probation 500 hour(s) community service		\$0	\$16,040

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Ventura County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
2010000523	Alvarez, Rafael	Claimant Fraud	180 day(s) jail 36 month(s) probation		\$15,024	\$200
2010016789	Anderson/ Bradley Stein & Lock, Christopher / Jam Sales, Inc.	Uninsured Employer			\$0	\$10,000
2009042149	Balloon Emporium & Party	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010024302	California Auto Plus & Smog	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010025074	Charline'S Urban Tapas	Claimant Fraud	24 month(s) probation		\$0	\$10,000
2010005055	Cull, Diane	Claimant Fraud	36 month(s) probation		\$2,000	\$100
2010025666	Danny, Garcia Uriel / Vallarta Bay Cantina	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2009046822	Davis, Scott / A Services, Inc.	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010043282	El Taco Fresh	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2011012646	El Tapatio	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010033255	Emma, Anthony / The Office Bar	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2011012645	Ghyczy, Robert / Kharma Lounge	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2011009281	Knox, Tyrone Joseph / Sunset Terrace Restaurant	Uninsured Employer	24 month(s) probation		\$0	\$10,000

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Ventura County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
2010033254	Los Compadres	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2008039742	Nuciforo, James / D&J Drywall	Premium Fraud	180 day(s) jail 36 month(s) probation	\$1,500,000	\$516,433	\$0
2008039742	Nuciforo, Michael Richard / D&J Drywall	Premium Fraud	180 day(s) jail 36 month(s) probation	\$1,500,000	\$516,433	\$0
2010034637	Ortega, Juana / Puerto Vallarta Restaurant	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010033258	Play Billiards	Uninsured Employer	24 month(s) probation		\$0	\$0
2010034637	Puerto Vallarta Restaurant	Uninsured Employer			\$0	\$10,000
2010023000	Rodriguez, Reynoldo / Rodriguez Brothers Farm	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010043621	Sancho's li	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2009034458	Snook, Jr., Robert Larry	Claimant Fraud	180 day(s) jail 36 month(s) probation		\$28,558	\$200
2011011936	Solis, Petra / La Cita	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2008039742	Stout, Brenda / D&J Drywall	Claimant Fraud	24 month(s) probation 75 hour(s) community service		\$0	\$0
2010033257	Super Nine Entrprises	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2010033250	The Hideaway Bar	Uninsured Employer	24 month(s) probation		\$0	\$10,000
2009041309	Villasenor, Hector Rocha	Claimant Fraud	60 day(s) jail 36 month(s) probation		\$3,424	\$0

Appendix 3 (continued)

Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011

Yolo County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
10SPN040	Anguiano, Jose	Other			\$0	\$2,000
10SPN039	Barry Lambert Fence	Uninsured Employer			\$0	\$1,000
10SWC008	Bell, John / Bell Painting	Premium Fraud	36 month(s) probation		\$11,901	\$1,770
10SPN035	Bueno, Francisco / Frank Exterior Paint & Concrete	Other			\$0	\$1,000
11SPN001	Chimira, Sam / Mermaid Sea Food & Grill	Uninsured Employer			\$0	\$25,000
10SPN042	Coleman, John	Uninsured Employer			\$0	\$1,000
10SPN038	Corona Sac Inc. / Roof Removal	Uninsured Employer			\$0	\$11,000
07SWC041	Currier, Robert / United States Postal Service	Claimant Fraud	30 day(s) jail 36 month(s) probation 80 hour(s) community service		\$0	\$160
10SPN034	Davalos, Luis I / Luis Handy Man	Uninsured Employer			\$0	\$3,000
10M06227	Douglas, Arthur B / U Hate It We Do It	Uninsured Employer	40 hour(s) community service		\$125	\$0
08SWC041	Dunham, Robert	Uninsured Employer	36 month(s) probation 80 hour(s) community service		\$0	\$1,130
10SPN053	Flores Iii, Mardardi	Uninsured Employer			\$0	\$1,000
08SWC015	Fuentes, Rocio	Claimant Fraud	45 day(s) jail 60 month(s) probation		\$10,936	\$1,309

Appendix 3 (continued)
Workers' Compensation Insurance Fraud Program
District Attorney Convictions - Fiscal Year 2010/2011
Yolo County

CASE NUMBER	SUBJECT NAME	ROLE	SENTENCE	ASSETS FROZEN	RESTITUTION	CRIMINAL FINE
08SWC050	Garcia, Antonio / International Home Repair	Claimant Fraud	12 month(s) probation		\$0	\$1,000
10M00168	Herrera, Luis M / L & S Landscaping	Uninsured Employer	36 month(s) probation		\$0	\$40,000
10SWC027	Husk, Jeffrey / JWH Custom Homes	Uninsured Employer	36 month(s) probation		\$0	\$40,190
10SPN043	Jagur, David Lal	Uninsured Employer			\$0	\$3,000
10F05439	Lemur, Grant / Dream Car Solutions	Uninsured Employer	36 month(s) probation		\$1,533	\$10,000
10SPN049	Long, Robin / Long's Handyman	Uninsured Employer			\$0	\$1,000
10SPN036	Mateo, Richard Lopez / Mateo Clean Cut Painting	Uninsured Employer			\$0	\$6,000
10SPN051	Rodrigues, Salvador Zamora / Zamora Gardening	Uninsured Employer			\$0	\$2,000
10SPN037	Rudy Concrete & Landscaping	Uninsured Employer			\$0	\$5,000
10SPN033	Snyder, Harold / The 54 Construction Company	Uninsured Employer			\$0	\$44,000
10SPN044	Suarez, Fabian / Suarez Landscaping Specialists	Uninsured Employer			\$0	\$4,000
09SWC024	Tracy, Walter / Self Employed	Uninsured Employer	12 month(s) probation 80 hour(s) community service		\$0	\$2,080
10SPN046	Waltower, Lindsay	Uninsured Employer			\$0	\$1,000
10SPN047	Wooley, Brett / Brett Wooley & Sons	Uninsured Employer			\$0	\$1,000

2011 ANNUAL REPORT

FINANCIAL SURVEILLANCE

BRANCH

Financial Surveillance Branch

The Financial Surveillance Branch (FSB) is responsible for conducting risk-focused financial surveillance of the insurance industry to ensure it can provide the benefits and protections promised to Californians. FSB's mission is to assure that all insurers licensed to do business in California (as well as those insurers operating on a non-admitted or surplus lines basis) maintain the financial stability and viability necessary to provide the benefits and protection they have promised their California policyholders.

FSB is composed of the Financial Analysis Division (FAD), the Field Examination Division (FED), the Actuarial Office (AO), the Health Actuarial Office (HAO), the Troubled Companies Unit (TCU), and the Premium Tax Audit Bureau (PTAB).

FAD, as part of the overall risk-focused financial surveillance process, evaluates and monitors the financial condition of insurance companies to identify financially distressed companies, and requires insurers to take corrective actions or recommends regulatory actions to assure insurer solvency for the protection of California consumers.

FED is responsible for conducting risk-focused financial examinations of California's domiciled insurance companies and other insurance organizations to determine their financial solvency and capacity to meet policyholder obligations. The examinations also serve to protect policyholder interests by including a review of corporate governance, key business activities such as claims, underwriting, investments and operations as well as an evaluation of prospective risks.

The AO oversees the determination of life insurer reserves, reviews selected portions of life insurance and annuity policy forms, ensures proper replacement of life Appointed Actuaries, verifies long term care loss ratio compliance, and reviews illustration certifications. The AO also provides general property-casualty actuarial support to FED and FAD as well as to the Rate Regulation Division for the workers' compensation line.

The HAO was established in September 2010 to provide resources dedicated to implementing the Department's response to the Federal health care reform legislation and to examine health insurance rates pursuant to Insurance Code Sections 10181, *et seq.* This has resulted in responsibility for most actuarial work related to health insurance being transferred from the AO to the newly formed HAO.

TCU is responsible for overseeing those insurers identified as being financially troubled.

PTAB is responsible for auditing premium tax returns filed by insurers and surplus lines brokers.

FSB utilizes the Early Warning System (EWS) to track all significant matters that may have an effect on the solvency of a company. The primary purpose of EWS is to facilitate early detection of potential insolvency problems with admitted insurance companies.

Financial Analysis Division

FAD analyzes and maintains ongoing surveillance of admitted insurers, fraternal benefit associations, grants and annuities societies, underwritten title companies, home protection companies, motor clubs, risk retention groups, surplus line insurers and Lloyd's syndicates. The purpose is to identify companies approaching hazardous financial condition and to recommend corrective action when necessary. FAD analyzes holding company transactions and acquisitions pursuant to the Insurance Holding Company System Regulatory Act. It assists the CDI Legal Branch by providing financial analysis of applications for certificates of authority, amended certificates of authority, securities permits, variable contract qualifications, underwritten title company licenses and various other corporate affairs matters. It also provides information and assistance to other divisions relative to reinsurance practices and procedures, surplus line insurers, captive insurers and risk retention groups.

The workload performed by the FAD is distributed among four bureaus as well as selected Division Office personnel. The following is an overview of FAD's workload statistics:

Workload Performed for the Year 2011

Financial Statements Analysis	Annual Statement	Quarterly Statement
Life and Property & Casualty	434	912
Other Entities	374	233

Corporate Affairs Applications	Number of Applications
Certificate of Authority	36
Holding Company Matters	288
All Others	158

Field Examination Division

Under the provisions of Sections 730, 733, 734.1 and 736 of the California Insurance Code, the Insurance Commissioner may examine the business and affairs of every admitted insurer, whenever deemed necessary, to determine its financial condition and compliance with applicable laws. Unless financial or other conditions warrant an immediate examination, domestic insurers are usually examined triennially and foreign insurers are usually examined in accordance with the NAIC's procedures for examination scheduling. FED also performs financial examinations of underwritten title companies, home warranty companies and other entities as necessary.

It is the responsibility of FED to determine the financial condition of insurance companies in accordance with California Insurance Code legal requirements and

prescribed accounting practices as promulgated by the NAIC. Examinations are conducted in accordance with the NAIC's Financial Condition Examiners Handbook. Various types of examinations initiated and completed by FED in 2011 are presented as follows:

Type of Examinations	Initiated	Completed
Domestic Companies	42	51
Underwritten Title Companies	10	4
Foreign Companies	1	0
Qualifying Exams	1	1
Statutory Exams	2	3
Total:	56	59

Actuarial Office

The AO provides technical assistance within the FSB and provides examination assistance to FED in the examination of domestic companies. The AO monitors reserves established by life and health insurance companies; drafts new legislation, regulations, and bulletins regarding actuarial matters; reviews selected portions of life insurance and annuity policy forms; and ensures compliance regarding Appointed Actuary changes, long term care loss ratios, and illustration certifications. Listed below are workload statistics of the AO:

Actuarial Reviews	Number Reviewed
Actuarial Memorandum for Statement Reserves	87
Regulatory Asset Adequacy Issues Summaries	478
Illustration Certifications	172
Individual Life Insurance Policies	582
Individual Annuity Contracts	359
Disability Income Rate Filings	13
Long Term Care Rate Filings	24
Credit Insurance Rate and Deviation Filings	11
Appointed Actuary Designations	55

Health Actuarial Office

The HAO provides technical assistance within FSB, including in particular review of health insurance rate filings and assistance in the formulation of policy related to health insurance reform initiatives and medical loss ratios. Listed below are workload statistics of the HAO with respect to review of health insurance rate filings:

Type of Coverage	Received	Completed
Major Medical	63	58
Medicare Supplement	197	182
Specific Disease	25	23
HIPAA & Conversion	5	7
All Others	45	35
Total:	335	305

Troubled Companies Unit

TCU is responsible for overseeing those insurers identified in the CDI's Early Warning System as being financially troubled. The number of companies under review does vary, as does the level of complexity each presents; an average of 76 companies is assigned to the TCU at any given time.

TCU monitors the financial status of assigned companies, and makes recommendations to the Early Warning Team. The Early Warning Team has ultimate responsibility for monitoring insurers determined to be in financial difficulty or troubled. TCU also provides other technical and administrative support for the Early Warning Team.

Premium Tax Audit Bureau

Insurance Taxes

Insurance premium taxes assessed in 2011 on business done during 2010, other than retaliatory and surplus line taxes, amounted to \$1,915,764,002. Premium taxes assessed for Medi-Cal Managed Care Plans in 2011 on business done during 2010 amounted to \$193,020,841. Premium tax refunds of \$5,395,694 were granted during the year.

Additional assessments proposed by the Insurance Commissioner to the Board of Equalization and the State Controller's Office totaled \$15,403,579.

Basis of Tax

The basis of tax is the amount of "gross premiums" received, less return premiums, upon business done in the State, with the exception of title insurance and ocean marine

insurance. Insurers transacting title insurance are taxed upon all income received in this State, with the exception of income arising out of investments. Ocean marine insurers are taxed upon underwriting profits.

Rate of Tax

A tax rate of 2.35 percent is imposed on “gross premiums” received, with the exception that a lower rate of 0.50 percent is applied to premiums received under pension and profit sharing plan contracts which are “qualified” under certain sections of the United States Internal Revenue Code. Title insurers are taxed at a rate of 2.35 percent of “income”. Ocean marine insurers are taxed at a rate of 5 percent of underwriting profits.

Retaliatory Taxes

Insurers domiciled in states with a higher tax rate than California pay a “retaliatory tax” to California equal to the difference in the tax rate of their state of domicile and the tax rate of the State of California.

Retaliatory taxes assessed and collected in 2011 on business done during 2010 totaled \$8,550,370.

Surplus Line Taxes

The surplus line tax rate is 3 percent and is assessed on surplus line premiums pursuant to California Insurance Code Section 1775.5. Surplus line taxes collected during 2011 on business done during 2010 totaled \$129,029,785.

2011 ANNUAL REPORT
LEGAL BRANCH

Legal Branch

The Legal Branch ensures compliance with the California Insurance Code by all admitted insurers, insurance agents and brokers, and any other person or organization engaging in or applying to engage in the business of insurance in California. The Legal Branch serves an integral part of the CDI's mission by litigating enforcement actions, reviewing and analyzing certain insurance policies to determine whether the policy should be approved for sale to consumers, analyzing the condition of insurers to determine whether certificates of authority or other corporate authorizations should be granted, providing legal services in connection with insurers determined to be insolvent, ensuring that rate filings comply with requirements of Proposition 103, and providing legal assistance to other branches of CDI. The Legal Branch provides legal services supporting the Fraud Division in the prevention of insurance fraud activity. The Legal Branch also promulgates regulations implementing California statutes, and provides legal services to CDI relating to service of process and records requests. A new bureau, Health Policy Approval, was formed in Legal Branch in late December 2011. The new bureau will provide focused resources to conduct health policy form reviews and implement health care related legislation. Formation of the bureau will facilitate more efficient policy form reviews of all policy types due to increased concentration on particular types of forms in each of the policy review bureaus. Legal Branch is headed by the Department's General Counsel, Adam M. Cole.

The Legal Branch is currently divided into eight bureaus:

- Auto Enforcement Bureau
- Enforcement Bureau - Sacramento
- Enforcement Bureau - San Francisco
- Fraud Liaison Bureau
- Government Law Bureau
- Health Policy Approval Bureau
- Policy Approval Bureau
- Rate Enforcement Bureau

Auto Enforcement Bureau

The Auto Enforcement Bureau (AEB) litigates enforcement actions against insurance companies and insurance agents and brokers (producers), specializing in actions related to automobile insurance marketing and claims. AEB protects the insurance public and the California insurance marketplace by ensuring that insurance producers and insurers comply with the Insurance Code and other laws and regulations that apply to the business of insurance.

AEB is responsible for the regulation of vehicle service contracts, including the review of contracts and forms, evaluation of provider license applications, and related license disciplinary matters. AEB handles administrative enforcement cases, preparing and filing pleadings in disciplinary actions against both licensed and unlicensed insurers and producers, seeking the revocation or denial of licenses or imposition of fines for unfair claims practices by insurers.

ACTIVITIES (JANUARY 1, 2011 THROUGH DECEMBER 31, 2011)

During the year, 377 matters were received and action was completed on 317.

Matter Type	Matters Opened	Matters Closed
Disciplinary	125	101
Vehicle Service Contract	236	182
Unfair Practices Act	1	2
Legal Opinion	5	6
Legislation (analysis of pending bill)	1	1
Miscellaneous	4	5
Human Resources	0	0
Order to Show Cause	3	16
Oversight	2	4
Total	377	317

Enforcement Bureau – Sacramento

The Enforcement Bureau-Sacramento (EB-SAC) litigates enforcement actions against insurance producers, insurers and others conducting insurance business in California. EB-SAC provides assistance to the Licensing Services Division in evaluating qualifications for licensure of producer applicants who have a criminal record or a record of professional license discipline, and reviewing legal documents implementing recommended action regarding those applicants.

ACTIVITIES (JANUARY 1, 2011 THROUGH DECEMBER 31, 2011)

During the year, 1415 cases were received and action was completed on 1058.

Order of Revocation	69
Order of Revocation/Issuance of Restricted License	16
Order of Denial	72
Order of Denial/Issuance of Restricted License	121
Order of Suspension	6
Order of Dismissal.....	8
Cease and Desist.....	0
Order for Monetary Penalty and or/Reimbursement.....	2

Order Removing Restrictions	81
Miscellaneous Orders.....	75
Warning.....	8
Voluntary Withdrawal of Application	3
No Disciplinary Action Warranted.....	42
No AR Action/Referred for Disciplinary Proceeding	257
Removal of Restrictions Denied	47
Order of Summary Denial.....	86
Order of Summary Denial/Issuance of Restricted License	81
Order of Summary Revocation	73
Order of Summary Revocation/Issuance of Restricted License	6
Barred from Licensure/Exam.....	5

Enforcement Bureau – San Francisco

The Enforcement Bureau-San Francisco (EB-SF) litigates enforcement actions against insurance companies and insurance agents and brokers (producers) EB-SF protects the insurance public and the California insurance marketplace by ensuring that insurance producers and insurers comply with the Insurance Code and other laws that apply to the business of insurance by initiating enforcement actions when it appears that a regulated person or company has violated California law.

Within EB-SF is the Health Insurance Bureau, formed to provide focused enforcement activities pertaining to health insurance. The bureau provides legal services to various units of CDI responsible for implementation of legislation relating to health insurance, and when appropriate, initiates enforcement actions against insurers and other regulated persons when violation of laws relating to health insurance is alleged.

ACTIVITIES (JANUARY 1, 2011 THROUGH DECEMBER 31, 2011)

During the year, 175 cases were received and action was completed on 154.

Order of Revocation	19
Order of Revocation/Issuance of Restricted License	12
Order of Denial.....	3
Order of Denial/Issuance of Restricted License	3
Order of Immediate Suspension.....	0
Order of Suspension	1
Order of Monetary Penalty &/or Reimbursement	5
Order of Dismissal.....	0

Order Removing Restrictions	1
Miscellaneous Orders.....	32
No Disciplinary Action Warranted.....	18
Warning.....	3
Order of Summary Revocation.....	8
Order of Summary Denial.....	0
Order to Cease & Desist	4

Enforcement Actions:

Unfair Practices Act Violations: (Monetary Penalties)

Title Insurance Violations:

Choice Home Warranty	\$10,000.00
Fidelity National Title Rate Overcharges	\$350,000.00
Frasca, Orlando	\$1,000.00
Rogers Insurance Services, Inc	\$1,000.00
Wedley, Wayne	\$1,000.00

Cease and Desist Orders:

- Choice Home Warranty
- Fidelity National Title Rate Overcharges
- Headley, Mark
- Nationwide Home Warranty

Fraud Liaison Bureau

The Fraud Liaison Bureau (FLB) provides legal support to the Department’s Fraud Division (FD). FLB provides support relating to the anti-fraud grant programs created by California statutes. The FLB attorneys provide legal support to the Division office, and the Regional offices, in the administration of these grant programs. This includes legal advice pertaining to provisions of the California Insurance Code, and its application to the grant programs, as well as the promulgation of regulations, drafting of proposed legislation, and related legal matters. FLB also provides legal advice related to Fraud Division’s peace officer functions such as search and seizure, and unique employment related issues due to the peace officer status of much of Fraud Division staff. FLB coordinated with the Office of the Attorney General when CDI or Fraud Division staff are regarding the conduct of a criminal investigation.

FLB also provides legal resources relating to qui tam cases filed with the Commissioner. Qui tam cases are complex civil actions filed by a whistle-blower under the Insurance Frauds Prevention Act set out in the California Insurance Code. These cases cover

alleged conduct including kickbacks in the sales promotion of drugs, misleading billing practices, or fabricated events, products, or services, submitted to a private insurer for payment as a claim. The Commissioner is served with copies of these lawsuits and may intervene in the cases. In 2011 the Commissioner intervened in qui tam lawsuits against a national pharmaceutical company and against a statewide hospital chain. In cases in which the Commissioner has not intervened, the Commissioner must approve the allocation of funds that result from a settlement or judgment against the defendant(s). On December 31, 2011, there were 48 qui tam cases pending in which the Commissioner had not intervened.

FLB Workflow: 2011

Matter Type	Matters Opened	Matters Closed	Pending at Year End
Qui Tam Litigation	12	0	48
Legal Opinions	5	5	0
Legislation(analysis of pending bill)	2	2	0
Miscellaneous	10	10	0
Human Resources	1	1	0
Regulation	0	0	0
Civil Litigation	50	0	0
Subpoenas/Public Records	2	2	0
Search Warrants	0	0	0
Oversight	2	2	0
Total	84	22	48

Government Law Bureau

The Government Law Bureau (GLB) provides legal support to the Legislative Office and for CDI’s rulemaking program. GLB serves as CDI’s agent for service of process and is the custodian of records. GLB participates in several inter-disciplinary task forces, including task forces relating to senior issues, workers’ compensation and catastrophe mitigation.

Statistics by Matter Type

Name	Assigned	Closed
Litigation – Defense/Other	24	24
Public Records Act Request	1,055	909
Subpoena	213	154
Substituted Service of Process	57	53
Legislation Oversight	18	3
Regulation Oversight	2	0
Total:	1,369	1,125

Policy Approval Bureau

The Policy Approval Bureau (PAB) performs reviews of life, disability (accident and health), and workers' compensation insurance products. PAB also reviews insurer qualifications to market and sell variable life and annuity products. PAB advises the public, other government agencies, CDI personnel and legislators on statutes and regulations pertaining to life, disability and workers' compensation insurance. Further PAB develops regulations and bulletins relating to life and disability insurance product design, advertising and administration.

Product	Submissions	
	Received	Closed
Group Non-Health	272	274
Supplemental Life Insurance	86	112
Variable Contracts	306	302
Group and Individual Health Insurance	512	587
Medicare Supplement	506	525
Unclassified	18	50
Individual Non-Health	82	67
Individual & Group Credit Insurance	14	16
Long Term Care Insurance	134	174
Workers' Compensation	473	404
Sub-Total	2,403	2,511
Variable Product Qualifications:		
Variable Annuity Qualification	0	0
Variable Life Qualification	1	0
Amended Variable Annuity Qualification	159	133
Amended Variable Life Qualification	71	56
Modified Guarantee Annuity Qualification	0	0
Sub-Total	231	189
Other Activities:		
Legal Opinions	1	2
Legal Service Request	0	0
Legislation	33	14
Litigation	8	21
Miscellaneous	2	0
Oversight	6	3
Regulations	4	2
Subpoena	0	0
Others	1	9
Sub-Total	55	51
TOTAL	2,689	2,751

Rate Enforcement Bureau

The Rate Enforcement Bureau (REB) enforces the provisions of Proposition 103 and other laws pertaining to the availability and affordability of insurance and the rating and underwriting practices of property and casualty insurers. REB provides legal support to the Department’s Rate Regulation Branch, represents CDI in prior approval rate hearings and represents CDI in administrative enforcement cases where rating and underwriting violations are alleged. REB provides legal assistance for issues related to the California Earthquake Authority, the Commissioner’s Catastrophe and Climate Change Initiatives, the California Automobile Assigned Risk Plan, and the California Low Cost Automobile Insurance Program.

A summary of the Bureau’s major actions for 2011 is set forth below.

Prior Approval

Petitions for Hearing Received.....	15
Petitions for Hearing Granted.....	2
Petitions for Hearing Denied	6
Notices of Hearing Issued	2
Hearings in Progress.....	2
Matters Resolved Without Hearing.....	6
Matters Resolved Following Hearing.....	0
Matters Pending	13

Regulations

Regulation Matters Opened	3
Regulations Approved.....	10
Regulations Pending	2

Enforcement Matters

Enforcement Matters Opened	1
Enforcement Matters Closed.....	1
Enforcement Matters Pending.....	9

Civil Litigation

Matters Opened	1
Matters Closed	0
Matters Pending	3

2011 ANNUAL REPORT

CORPORATE *and* REGULATORY
AFFAIRS BRANCH

Corporate and Regulatory Affairs Branch

Branch Overview

The Corporate and Regulatory Affairs Branch (CARAB) was created in January 2012 when Corporate Affairs Bureaus I and II were split off from the Legal Branch to form a new branch to focus on insurer governance, licensing and solvency oversight. CARAB protects California consumers through company licensing, oversight and enforcement that protects insurers' solvency and requires the conduct of company affairs in accordance with the law. Program areas handled by CARAB include insurer corporate applications, troubled companies, surplus lines, risk retention and risk purchasing groups, and providing legal advice and assistance to the Financial Surveillance Branch and the Conservation & Liquidation Office.

Structure

CARAB is headed by a Deputy Commissioner, John F. Finston. CARAB is comprised of two bureaus: Corporate Affairs Bureau I and Corporate Affairs Bureau II. The two bureaus are each headed by an Assistant Chief Counsel.

Corporate Affairs Bureau I

The Corporate Affairs Bureau I (CAB I) specializes in the areas of surplus lines, risk retention and risk purchasing groups, title and underwritten title companies, insurer name approvals, premium tax issues and charitable gift organizations. In addition, CAB I reviews applications filed by insurance companies for approval of securities issuances, mergers, acquisitions, inter-affiliate service agreements, holding company act filings and extraordinary dividend payments.

Corporate Affairs Bureau II

The Corporate Affairs Bureau II (CAB II) specializes in the areas of reinsurance, non-standard company structures, and life settlements. In addition to handling corporate licensing and oversight, provides legal services to Financial Surveillance Branch's Troubled Companies Unit and to CDI's Conservation & Liquidation Office (CLO). The CLO takes over and manages insurers found to be in such a condition that further transaction of business would be hazardous to their policyholders, creditors or to the public. The goal is to protect those stakeholders, and in the case of liquidation, maximize return to policyholders and creditors.

Application Type	Begin # Assigned Cases	Assigned	Closed	End # Assigned Cases
Advisory Organization License	1	1	1	1
Approval of Trust	12	10	4	18
C/A Amend-Add Line	25	34	31	28
C/A Amend-Domestic Change 709.5	0	1	0	1
C/A Amend-Name	6	31	30	7
C/A Amend-Non-Domestic Redomicile	5	21	25	1
Certificate of Authority	11	22	20	13
Certificate of Authority Status - 700C	14	1	14	1
Custodian Qualification	3	3	4	2
Custody Agreement	3	10	12	1
Failure to Make Required Filing	8	33	37	4
Grants/Annuities - C/A	28	13	22	19
Grants/Annuities-Amended C/A	2	2	2	2
HC Disclaimer of Affiliation .4l	14	6	8	12
HC Exempt - Comm. Domiciled Status .13b	0	6	4	2
HC Exempt - Form A .2f	2	16	9	9
HC Extraordinary Dividend .5g	1	26	25	2
HC Mgt. Serv./Cost Share Agmt .5b4	79	117	120	76
HC Misc.	1	1	2	0
HC Reinsurance .5b3	27	13	19	21
HC Sales Purchases Loans .5b1	3	8	7	4
Holding Companies Acquisition	3	7	7	3
Home Protection	0	3	1	2
Letter of Credit	0	6	5	1
Life Settlement Provider	31	2	11	22
Merger	5	9	10	4
Miscellaneous	22	18	22	18
Motor Club Service Contract	8	10	15	3
Name Approval Reservation	28	97	95	30
Organizational Permit	1	0	1	0
Purchasing Alliance Registration	1	0	1	0
Rein/Sale-Purchase/Transfer-Assumption	11	21	22	10
Reinsurer Accreditation	2	34	26	10
Risk Purchasing Group	7	28	21	14
Risk Purchasing Group Renewal	31	278	287	22
Risk Retention Group	12	10	11	11

Application Type	Begin # Assigned Cases	Assigned	Closed	End # Assigned Cases
Risk Retention Group Renewal	70	76	91	55
S810	1	2	2	1
Stock Permit	2	5	3	4
Stock Permit - Amend	0	1	1	0
Surplus Line Filing	7	0	7	0
UTC-Amend License	3	6	3	6
UTC-License	0	3	1	2
UTC-Organizational Permit	1	4	2	3
UTC-Permit	0	3	2	1
UTC-Transfer of Shares	5	8	8	5
WC Deposit Agreement	0	31	29	2
Withdrawal	16	8	15	9
TOTAL	512	1,045	1,095	462

2011 ANNUAL REPORT
OFFICE *of the* SPECIAL COUNSEL

Office of the Special Counsel

The Special Counsel provides independent legal advice directly to the Insurance Commissioner, provides oversight of Department Rulemaking Projects and Regulations, directs the interaction with the National Association of Insurance Commissioners (NAIC), and manages various special projects and Commissioner-initiatives.

- **Legal Advice** - The Special Counsel provides the Commissioner with independent legal advice on various issues regarding litigation, adjudicatory proceedings and other legal matters. In 2011, for example, the Special Counsel acted as “in house counsel” on several litigation matters, interfacing with Deputy Attorney Generals and advising the Commissioner and Chief Deputy Commissioner, as well as handling approximately 10 adjudicatory matters from the Department’s Administrative Hearing Bureau (AHB) that conducts hearings on insurance rate plans, workers’ compensation matters and other disputes.
- **Rulemaking Proceedings** - Oversight of the Department’s Regulations is vested with the Special Counsel. This process includes regulation development, research, interaction with the insurance industry and other stakeholders and navigating the requirements of the Administrative Procedure Act (APA) in conjunction with the Office of Administrative Law (OAL). In 2011, the Department has approximately 25 active Rulemaking Projects.
- **National Association of Insurance Commissioners (NAIC)** - Coordination and facilitation of the Department’s interaction with the NAIC, its participation on NAIC Committees, Task Forces, and Working Groups is handled by the Special Counsel. As the largest insurance market in the nation, California plays a significant role in helping shape model laws and regulatory policy. Doing so involves active participation in National Meetings and conference calls with regulators from other states. In 2011, California was a Member on approximately 28 NAIC bodies, and monitored approximately five others.
- **Special Initiatives** - The Special Counsel also manages various special projects or initiatives for the Commissioner involving policy and law such as discretionary clauses, pet insurance, green insurance and others. In 2011, for example, the Special Counsel assisted the Insurance Commissioner in his leadership of the effort to survey the insurance industry on the impact of climate change on insurance companies.

2011 ANNUAL REPORT

POLICY *and* PLANNING BRANCH

Policy and Planning Branch

The Policy & Planning Branch (renamed Policy & Regulations in 2007) resumed its previous name in 2011 to more accurately reflect its increased and changed responsibilities under new Insurance Commissioner Dave Jones. The Branch shouldered the lead responsibility for the following:

- Supports the Commissioner's Executive Management Team's research and analysis on emerging insurance issues with policy implications.
- Conducts data calls mandated by statutes and regulations.
- Identifies and measures trends in the insurance marketplace to support the Commissioner's decision-making process
- Supports Commissioner-directed policy initiatives such as negotiating and drafting the settlement agreements with insurers to enforce mental health parity laws
- Coordinates far-reaching consumer summits and implementing the Commissioner-assigned consumer suggestions resulting from these diverse, informative stakeholder meetings.

The Policy & Planning Branch is comprised of the Statistical Analysis Division and the Special Projects Division. To continue re-focusing and streamlining the branch to meet the needs of the insurance marketplace in these constrained public agency budgetary times, the Policy Research Division was consolidated into the Special Projects Division.

Special Projects Division

The Special Projects Division (SPD) advances the Commissioner's policy ideas and initiatives by performing requested targeted research, analysis, development, and implementation and coordinating the efforts of working groups. In 2011, it also supported the Special Counsel Branch, managing the daily communications between the National Association of Insurance Commissioners (NAIC) and the California Department of Insurance (CDI), supporting the Green Insurance Summit, and monitoring regulations.

Targeted research projects in 2011 included:

- Research the scope of the Mental Health Parity Act and its applicability to behavioral health treatment for autism;
- Research the impact of having an elected, as compared to an appointed, Insurance Commissioner, on rates, with a focus on prior approval rate filing laws and automobile premiums;
- Compile comparison of selected insurer premium and commission data;
- Research temporary reinsurance programs required of each state by the Affordable Care Act;

- Analyze pre-2006 data sent in by outside stakeholder about auto rating factors, zip code v. census tract, and credit scoring to request changes to regulations amended in 2006;

Development and implementation projects in 2011 included:

- Compile the Annual Report and deliver to the Governor and Legislature;
- Compile the Rulemaking Calendar and deliver to the Office of Administrative Law;
- Compile and organize the periodic lists from a federal agency into a comprehensive list by accused's name;
- Assist SAD with distribution of Child Support Services Insurance Match inquiry form and tabulation of responses;
- Plan, coordinate, staff, and summarize two Consumer Summits (June-Sacramento; October-San Francisco);
- Assist in preparing the information package to present to the State Senate Subcommittee Special Hearing for SB 946;
- Request the implementation plan for consumer suggestions received at the Consumer Summits;
- Staff meetings with another agency to discuss how to share information, including how to best utilize federal reports, and be available to provide assistance with inter-agency Memorandum of Understanding;
- Summarize task force meetings, Consumer Summit discussions and regulations workshops and hearings.

Working group projects in 2011 included:

Senior Issues Working Group (SIWG):

Assist coordinate finalizing the Senior Annuity DVD, which advises seniors about deceptive practices in the marketing and sale of annuities and how to protect themselves against being deceived; assist research of prospective long term care regulations; help review and place Enforcement of Independent Medical Review Statutes Bulletin to insurers and interested parties on appropriate page of public website; help organize the Elder Financial Abuse Prevention Inter-agency Roundtable (EFAIR), designed to enable agencies to share information and collaborate more effectively to protect seniors; help distribute and post the Department of Corporations' Senior Resource Guide; help circulate draft Senior Advisory and assist CEOB with final distribution; help management track timelines for the referral, investigation, and enforcement action phases of three cases;

Catastrophe Mitigation working group:

Propose modifications to the draft Fire Line Equations to include mitigation factors into the calculation of the hazard risk, and premium; help with

Memorandum of Understanding (MOU) with CalFire about preventing and mitigating fire losses;

Workers' Compensation (WC) working group:

Assist with the WC Rating Organization Website regulations; begin the analysis into WC premium credits and debits and loss ratios for certain-sized insurance risks; help draft WC working group Strategic Plan; attend meeting with the Department of Industrial Relations and self-insurance representatives to investigate ideas for addressing self-insurance plans; meet with WC Insurance Rating Bureau Governing Board public members; meet with outside stakeholders about WC experience modification concerns; help preparations for WC Pure Premium Cost Benchmark Hearing

Administrative projects in 2011 included:

Help management organize and formulate the Strategic Plan Questionnaire for Executive Management to send to each branch; assist management create the Commissioner's Priorities internal spreadsheet; merge a working unit into SPD and re-assign that unit's members projects; help draft branch Strategic Plan; help draft branch fiscal year 2012-13 Budget Change Proposal; coordinate applications of student externs; help answer branch Strategic Planning Questionnaire; revise and update existing position Duty Statements, Performance Evaluations, and Statement of Expectations for SPD; draft the revised Administrative Bulletin to return Mandated Reports monitoring responsibility to the appropriate CDI work unit.

Statistical Analysis Division

The Statistical Analysis Division (SAD) is based in Los Angeles and is responsible for responding to all data collection and reporting requirements set forth in the California Insurance Code and the California Code of Regulations. The data, analysis and reports developed by SAD help the Insurance Commissioner and management, the Legislature and related government agencies support a healthy insurance marketplace and provide California's consumers with information to help them make important insurance decisions.

SAD maintains databases on a variety of insurance lines. On an annual basis, SAD conducts in-depth analysis on a multitude of data elements submitted by the insurance industry and other sources. SAD evaluates, compares and interprets massive raw data and statistics in order to maintain annual and semi-annual reports based on that data. In addition, SAD analyzes and develops legislation related to the collection of data by the Department.

SAD has provided data and related research assistance to virtually every unit in the California Department of Insurance - Actuarial Division, Consumer Services, Financial Analysis, Fraud, Legal, Licensing, Press Office and Rate Regulation. In addition to CDI internal units, SAD's data and reports are used by the public, consumer groups, industry, the media, university students and professors, federal and state lawmakers.

1. During 2011, SAD Performed Extensive Analysis of:

- Private Passenger Automobile Liability and Physical Damage Experience by ZIP Code, as required by California Insurance Code Section 11628(a).
- Annual Private Passenger Automobile and Homeowners Premium Comparison surveys in accordance with California Insurance Code Section 12959.
- Annual Consumer Complaint Ratio Study, in accordance with California Insurance Code Section 12921.1.
- Workers' Compensation Claims Adjusters, Medical-Only Claims Adjusters and Medical Bill Reviewers under California Insurance Code Section 11761 and California Code of Regulations Title 10, Chapter 5, Sections 2592 – 2592.08.
- Annual Long-Term Care Insurance Consumer Rate and History Guide, as required by California Insurance Code Section 10234.6.
- Annual Long-Term Care Insurance Experience Survey, in accordance with California Insurance Code Sections 10232.3(h), 10234.86, 10234.95(l), and 10235.9.
- Medicare Supplement Insurance Consumer Rate Guide, in accordance with California Insurance Code Section 10192.20.
- Community Service Statement Data call, as required by California Code of Regulations Title 10, Chapter 5, Section 2646.6.
- Community Development Investment Policy Statements Data Call, as required by California Insurance Code Section 926.3 (b).
- Health and Disability Insurance Data Call conducted under California Insurance Code Sections 10508.6, 10508.7, 1872.85, 700(c) and 900.
- California Seismic Assessment Project, as required by California Insurance Code Section 12975.9.
- Disability Fraud Assessment Table and Report Development, in accordance with California Insurance Code Section 1872.85.
- California Healthcare Benefits Fund Assessment Table and Report Development, in accordance with California Code of Regulations 2218.62 (AB1996).
- Long-Term Care Insurance Agents Data Call (Semi-annual), as required by California Insurance Code Section 10234.93(a)(3).
- Developed a list of insurance companies currently offering health insurance coverage in accordance with California Insurance Code Section 10133.66.
- Personal Property Coverage and Limits pursuant to California Insurance Code Section 16014(b).
- Fraud Assessment Table and Report Development, in accordance with California Insurance Code Section 1872.86.

- Bureau of Fraudulent Claims Table and Report Development, in accordance with California Insurance Code Section 1874.8.
- Mental Health Services Company Exhibits, SAD worked with Legal Division to incorporate additional Company Reporting Exhibits in the annual Health & Disability Insurance Data Call to collect and track company compliance under California Insurance Code Sections 10144.5(a), 10123.198 and 10123.199. Data is reported annually to Legal Division.
- Workers Compensation Policyholder Appeals Data Call, in accordance with California Code of Regulations Title 10, Chapter 5 Section 2509.43 et. seq.
- Health Insurance Dispute Resolution Data Call conducted under California Insurance Code Sections 10123.127. Collected experience data on a company's "Health Dispute Resolution Mechanism." This data was submitted to Legal Division.

2. Special Projects Requested by Executive Staff/Commissioner:

In addition to annual data calls, SAD also conducts research and data collection for special projects. These special projects are a result of "hot topic" policy issues that the CDI executive staff faces throughout the year.

- **Designated Office of Consumer Appeals for Workers Compensation** - Provided the Commissioner, Office of the Ombudsman and Legal Division with designated contact information by company pursuant to California Code of Regulations Title 10, Chapter 5, Section 2509.43.
- **CSEP Insurance Match Survey** - Working with the California Department of Child Support Services (DCSS) and the Special Projects Division (SPD), the Statistical Analysis Division (SAD) developed a survey designed to identify companies participating in Insurance Match Programs.
- **Health Insurance Agents Commissions Data Call** - Working with the Legal Division and the Health Policy Branch, the Statistical Analysis Division (SAD) helped design a survey collecting Premiums and Commissions from years 2000 to 2010. In addition, SAD developed forms and instructions to collect data and correspondence on Agents Commission Rates and related materials.
- **ABA-Behavioral Intervention Therapy Network Data Call** - Working with CDI Legal Division and Field Rating & Underwriting, the Statistical Analysis Division (SAD) assisted in the release of a data call pertaining to requirements under CCR Title 10 Sec. 2240.
- **Company Diversity Program 2011 Data Call** - a voluntary special-purpose data call to determine if insurance companies have a diversity statement and/or implemented a Supplier Diversity Program.

3. Research Consultation/Database Development:

At various times throughout the year, SAD provides technical assistance in developing databases or assistance in conducting analysis of data for CDI internal branches as well as other state or insurance related agencies. The following is a list of the SAD's research consultation/database development activities during 2011:

- **U.S. Department of Health and Human Services (HHS) Data Request** – Responded to a request from HHS concerning California Health Insurance Plans.
- **National Association of Insurance Commissioners (NAIC) Data Request** – Responded to a request from NAIC concerning Health Premium Rate Review Data.
- **2000 – 2010 Long-Term Care Insurance Experience data** – Responded to a request for data from the California Dept. of Health Services (Partnership for LTC Division).
- **CIC 1872.86 Tracking System** - Developed a database and tracking system to Support Collection of Fraud Assessments under California Insurance Code Section 1872.86. SAD worked with Accounting Services Bureau to develop a system to track companies and send notifications.
- **Language Assistance Program Implementation & Enforcement** – In response to a request from Legal Division, SAD was asked to develop a report database to assist in their analysis of the individual company form filings. SAD senior staff worked with attorneys from Legal Division to create an interactive database that improved access and review of data and the ability to develop summary reports of the file review process.
- **Fraud Vehicle Assessment** – Provide CDI Accounting staff with private passenger automobile exposure database for audit purposes in regards to the Fraud Vehicle Assessment payments from insurers (California Insurance Code 1872.8).
- **National Association of Insurance Commissioners (NAIC) Annual Reports** - Provided Private Passenger Automobile and Personal Property information to the NAIC for their annual reports.
- **Commission on Health and Safety and Workers' Compensation (CHSWC) Annual Request** - Provided workers' compensation related data to the CHSWC for their annual reporting on the health, safety, and workers' compensation systems in California.
- **California Earthquake Authority (CEA) Data Requests** - Provided homeowners and earthquake data to the CEA in order for them to assess the earthquake insurance market.

4. Request for Data/Consumer Inquiries Received During Calendar Year 2011:

During calendar year 2011, SAD provided data for and handled inquiries received by the CDI's Consumer Hotline. Eighty two separate inquiries came from individual consumers, other state and federal agencies, university students and professors, and the insurance industry.

2011 ANNUAL REPORT
LEGISLATIVE OFFICE

Legislative Office

In the first year of Insurance Commissioner Dave Jones' Administration leading the California Department of Insurance (CDI), the Legislative Office (LO) staffed 12 bills sponsored by Commissioner Jones and CDI. Of the 12, two have become two-year bills and one has been reintroduced in a separate legislative "vehicle" for 2012. The LO successfully shepherded the remaining nine bills through the legislative process to the Governor's Office, of which Governor Jerry Brown signed all nine bills into law.

In addition to strongly advocating for CDI's twelve sponsored bills last year, the LO closely monitored, provided technical assistance to, took positions on, and/or advocated for or against 80 bills in 2011 that were sent to Governor Brown for his consideration; 70 of these bills – 37 out of 44 Assembly bills and 33 out of 36 Senate bills – were subsequently signed by the Governor. LO also was engaged on and tracked more than 150 other bills that were introduced and amended throughout 2011 that did not make it through the legislative process and to the Governor's desk.

Below are brief summaries of the nine CDI-sponsored bills that were signed into law in 2011:

1. **AB 315 authored by Assembly Insurance Committee Chair Jose Solorio (Chapter 83).** This urgency law adds uniformity and simplicity to California's regulatory law as it pertains to the surplus lines insurance marketplace and the state's surplus lines tax collection activities. It conforms state law to mandatory changes mandated in the Nonadmitted and Reinsurance Reform Act provisions of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 in order to avoid preemption by the federal government.
2. **AB 624 jointly authored by Assembly Speaker John A. Pérez and Assembly Budget Committee Chair Bob Blumenfield (Chapter 436).** This new law extends the sunset date to January 1, 2015 on the California Organized Investment Network's (COIN) Tax Credit Program, which was set to expire at the end of 2011. Extending the COIN program ensures that this successful partnership between insurance companies and community based organizations can continue to provide funding for important projects in underserved communities throughout the state, an effort that is especially important in these difficult economic times. While California continues to pull itself out of the recession, programs like COIN are vital to facilitating that momentum by providing new capital for small businesses throughout the state, spurring growth in our neighborhoods, and, most importantly, creating more badly needed jobs for Californians. The COIN program, in partnership with Community Development Financial Institutions, has invested more than \$100 million into underserved communities.
3. **AB 689 authored by Assembly Budget Committee Chair Bob Blumenfield (Chapter 295).** This new law establishes landmark consumer protections in the annuities marketplace to protect the public, particularly seniors, from fraudulent activities involving these complex insurance products. For far too long, seniors have

been victimized through the aggressive marketing and sale of annuity products that are simply unsuitable for them. Consumers unwittingly buy these products not realizing that their invested funds will not be available to them or their funds are terribly expensive to recover if they want to withdraw their money to pay for immediate expenses, which can be financially devastating to seniors on a fixed income. With Californians spending \$20.7 billion on annuities in 2010 alone, this new law requires insurers, agents, and brokers to verify that an annuity purchase, exchange, or replacement is appropriate for the consumer based on an evaluation of his or her age, income, financial objectives, and other important factors. It also authorizes the Insurance Commissioner to revoke an insurance agent's license, impose fines, and restore money lost to the consumer when suitability standards are violated.

4. **AB 793 authored by Assembly Banking & Finance Committee Chair Mike Eng (Chapter 223).** This new law limits insurance agents' and brokers' ability to "cross-sell" reverse equity mortgages and annuities. The growth of the reverse mortgage business has been accompanied by aggressive marketing and predatory abuse, especially when reverse mortgages are marketed along with insurance products or financial investment vehicles.
5. **AB 1416 authored by the Assembly Insurance Committee (Chapter 411).** This new law makes several necessary changes to various Insurance Code sections regarding agent licensing, training, and previously enacted legislation. It also permits the Insurance Commissioner to remove a life agent's authority to transact variable life insurance contracts upon learning that the agent is no longer registered to transact securities with the U.S. Securities and Exchange Commission or the Financial Industry Regulatory Authority. The current process is time consuming, leaving the door open for a life agent to continue selling these insurance products when they are no longer authorized to do so. Timelier removal of a life agent's variable contract authority better protects consumers from agents who are not authorized to sell annuities or other complex variable life contract products.
6. **SB 51 authored by Senator Elaine Alquist (Chapter 644).** This new law requires health insurers and HMOs to put a larger share of the money they collect from consumers into actual medical care instead of overhead and profits. While it does not control or limit health insurance rate increases, this new law reinforces what is required in President Barack Obama's Affordable Care Act (ACA), which requires HMOs and health insurers to have a medical loss ratio (MLR) of 85% for large group health insurance and 80% for small group and individual health insurance – meaning that insurers and HMOs have to put 85% of what they collect from large employers and 80% of what they collect in premium from individuals and small employers into actual medical care versus that portion of the premium which goes to insurer or HMO overhead and profit.
7. **SB 599 authored by Senate Appropriations Committee Chair Christine Kehoe (Chapter 423).** This new law requires life insurers to obtain a beneficiary's written declaration as to how he or she wants to receive their benefit payment. Instead of

sending life insurance beneficiaries a check for the full amount of benefits owed, many life insurance companies automatically deposit the benefits into a Retained Asset Account (RAA). This issue first came to the attention of Commissioner Jones when military families complained that they had not been asked for permission before the life insurance benefits of loved ones who died in military service were put into a RAA by life insurers. Now, military families as well as all Californians will be able to decide for themselves how they want their life insurance benefits to be paid by requiring insurers to get their permission, based on strong consumer disclosures, before putting their benefits into a retained asset account controlled by the insurer. This new law is part of a two bill package with enacted SB 713, a companion RAA-disclosure bill, authored by Senate Insurance Committee Chair Ron Calderon (Chapter 130).

8. **SB 621 authored by Senate Insurance Committee Chair Ron Calderon (Chapter 425).** This new law protects consumers of life, health, and disability insurance from “discretionary clauses” in their insurance policies, which give the insurer the sole discretion to decide if a beneficiary has become disabled, even if the consumer has a doctor certify that they are disabled. Discretionary clauses have been increasingly relied upon by insurers to reject legitimate claims for disability insurance when a consumer becomes disabled – insurers know that many consumers will give up their claim and that those who challenge the claim denial face a very high legal burden to overcome the denial since the discretionary clause vests sole discretion in the insurer to decide if the consumer is disabled. This new law levels the playing field and gives consumers an even chance to prove that they are entitled to disability and other insurance, by making the “discretionary clauses” that insurers have been putting into their insurance policies as void and unenforceable.

9. **SB 684 authored by Senate Majority Leader Ellen Corbett (Chapter 566).** This new law protects California's businesses by preventing workers' compensation insurers from unilaterally forcing California businesses to other states like New York or Delaware to resolve disputes, without the California business's consent. It protects California businesses by requiring that there be disclosure up front at the time a quote is provided as to where the insurer proposes to resolve disputes and by making explicit that California businesses can decline to agree to being forced to arbitrate or otherwise resolve disputes in other states than California. This new law reduces costs for California businesses associated with having to fly managers and lawyers to places like New York or Delaware to resolve disputes that could just as easily be resolved here in California.

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COMMUNITY PROGRAMS BRANCH

Community Programs Branch

The Community Programs Branch (CPB) works to proactively connect the California Department of Insurance (CDI) with California consumers. To achieve this mission, CPB creates and sustains collaborative partnerships with community groups, consumer organizations, small businesses, non-profits, insurance industry organizations and individuals, as well as federal, state and local government entities.

We disseminate consumer information on complex insurance issues and educate consumers on the availability of programs and consumer protection services available through the California Department of Insurance. CPB delivers services through the CPB Deputy Commissioner's office, Administrative Hearing Bureau (AHB), Consumer Education and Outreach Bureau (CEOB), Community Organized Investment Network (COIN), the Office of the Ombudsman (OMB) and California Low Cost Automobile Insurance Program.

Consumer Education and Outreach Bureau

The Consumer Education and Outreach Bureau (CEOB) educates consumers on insurance issues and the availability of CDI as a resource to Californians. CEOB develops and distributes informational guides and coordinates and participates in educational and outreach events.

CEOB is involved in the development of Insurance Recovery Forums and the coordination of hearings and special events for the Insurance Commissioner. When necessary, CEOB assists in disaster outreach events following major disasters in the state.

Throughout the year, CEOB distributed over 209,889 insurance related informational guides and coordinated or participated in more than 236 outreach events throughout the State as follows:

Senior Events	76
Youth/Parent/Faculty	15
Planning Meetings	04
Emergency Preparedness	04
Insurance Recovery Forums.....	01
Consumer Oriented	33
California Low Cost Auto.....	103
Total Events & Meetings	236

CEOB is responsible for creating, updating and publishing insurance consumer information guides for the Department. These guides have been developed as a result of consumer need or to meet statutory provisions. The majority of these information guides may be found on the California Department of Insurance Website at www.insurance.ca.gov.

Life and Annuity Consumer Protection Program

CDI is tasked with educating consumers on all aspects of life insurance and annuity products, consumer protection, purchasing and using insurance and annuity products, claims filing, benefit delivery, and dispute resolution for the LACPP program.

For 2011, CEOB continued to provide consumer education to seniors by advertising in various statewide publications as shown below:

Publication	Circulation
AARP	58 Counties
Senior Magazine	Sacramento, Yolo, El Dorado, Placer Counties
Today's Senior Magazine	Sacramento & Above
Life After 50	Ventura to San Diego
Spectrum Magazine	Sacramento & Surrounding areas
After 55	San Francisco, Bay Area & San Diego
San Joaquin	County of San Joaquin
WEBSITE:	
Aging Services	Web page button
Southern California Senior Resources	Web page button

The Senior Information Center located on CDI's website at www.insurance.ca.gov/0150-seniors/ provides useful information through alerts, advisories and press releases issued by CDI.

The Health Plan section provides links to programs and resources such as:

- Health Insurance Counseling and Advocacy Program (HICAP)
- Medicare's Office site for Medicare Advantage Plan
- California Health Advocates
- Social Security On-line
- California Department of Aging
- 2011 Guide to Medicare Supplement Insurance
- California Department of Health Care Services

The site includes a senior event calendar, videos, insurance guides-specific to seniors and a glossary created specifically for seniors from questions on insurance terms.

Funding for LACPP activities is expected to continue until January 1, 2015. To pay for this outreach program, each insurer pays a \$1 fee on each individual life insurance policy and each annuity product with a value greater than \$15,000.

PATIENT AND PROVIDER PROTECTION ACT (PPPA)

California Insurance Code Section 10133.66 requires that CDI “provide announcements that inform health insurance consumers and their health care providers of the department’s toll-free telephone number that is dedicated to the handling of complaints and of the availability of the Internet Web page established under this section, and the process to register a complaint with the department and to submit an inquiry to it.” For 2011, CEOB utilized the following magazines in order to meet the requirements of the Patient and Provider Protection Act.

Publication	Distribution
California Family Physicians	7500 Physicians + members in private and group practices
California Medical Association	25000 Physician subscribers
California Ambulatory Surgery Association	325 members
American Congress of Obstetricians and Gynecologists	5000 members
California Association for Nurse Practitioners	2500 members
American College of Emergency Physicians	3500 members

CEOB will also purchase search engine advertising to advertise CDI’s ability to help health consumers and providers resolve disputes with insurers.

California Low Cost Automobile Outreach

The California Low Cost Automobile Insurance Program (CLCA) was established by the Legislature in 1999 and exists pursuant to California Insurance Code Section 11629.7 as a program designed to provide low income or income eligible persons with liability insurance protection at affordable rates as a way to meet California's financial responsibility laws. CLCA continues to demonstrate excellent results for Californians. Since the program’s inception, 79,629 Californians have received insurance through the

program. There were 9,791 policies in force at the end of 2011. Recent changes to the program include a new website at www.mylowcostauto.com, issuing Temporary Proof of Insurance Cards, eliminating the two-week wait for mailed proof of insurance cards that are needed to register a car with the Department of Motor Vehicles, and acceptance of debit and credit cards through CAARP's online system. The California Department of Insurance (CDI) and California Automobile Assigned Risk Plan (CAARP) are working to implement Assembly Bill 1024 (Hueso, 2011), which required CDI and CAARP to set up a process to accept online applications for California's Low Cost Auto Insurance Program. CDI tested new advertising methods such as bus advertising, wrapped 3 CDI cars, laundromat machine advertising, gas station advertising, online Google ads and a SMS Text Campaign to reach income-eligible Californians and extend our message beyond billboards and radio ads. The program meets the success standards established under the law:

- The rates were sufficient to cover losses and expenses. A rate decrease averaging 4 percent is expected in Spring 2012.
- The program benefitted low-income communities. In fact CAARP Statistics documents about 85% of policies issued in 2011 were issued to applicants whose household income was at or below \$20,000 per year, and the predominant vehicle value was less than \$5,000 for 71% consumers.
- According to CAARP, 59% of new policies assigned were to applicants who were uninsured at the time of application.
- In addition to the CLCA insurance policies, new tracking shows that approximately 50 motorists per month visit a producer because of the program's advertising and leave with auto insurance "better" than a CLCA policy.

To view the CLCA Annual Report to the Legislature, please visit http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0010-automobile/lca/upload/CLCA_LegReport_Website.pdf

California Organized Investment Network Unit

The mission of the California Organized Investment Network (COIN) Unit is to guide insurer capital into safe and sound investments that provide fair returns and social and economic benefits to traditionally underserved communities. In October 2011, AB 624 (Perez) was chaptered, and amended Insurance Code §12209 to extend the COIN CDFI tax credit program until January 1, 2017. This bill also amended §12939.2 to reestablish the COIN Advisory Board.

The COIN Unit carries out this mission through two distinct program areas; the COIN Insurer Investment Programs and the California Community Development Financial Institution (CDFI) Certification and Tax Credit Programs. In late 2011, a Managing Director and an Investment Officer joined the COIN Unit in its new Los Angeles location. A team of three COIN investment officers continues to work out of the Sacramento office.

Insurer Investment Programs

COIN encourages insurers to invest in community development through its Data Call and Bulletin programs. Data Calls track insurer investments over a multi-year time horizon. Investment Bulletins are vehicles through which qualified investment funds, projects or programs may actively seek insurer capital. These investment proposals satisfy principles of a safe, sound and solvent investment offering an acceptable financial return while benefiting the environment, low-income and rural communities, or by adding value to the supply of capital to low-income and rural markets and products.

Community Development Policy Statements

In 2010, Assembly Insurance Committee Chair Jose Solorio authored AB 41, requiring each insurer that collects more than \$100 million in premiums from Californians to file a policy statement that details a company's goals for community development and infrastructure investments in underserved communities.

Of the 203 insurers that were required to file policy statements, 199 complied with the new law. Four failed to submit reports so Commissioner Jones sent their CEO's a letter asking them to do so. All four companies subsequently submitted their policy statements. Sixty-seven other companies voluntarily filed statements. A list of the companies that filed, along with their policies statements, and those that didn't file, are available on the Department web site at www.insurance.ca.gov/COIN.

CDFI Programs

The COIN Unit certifies tax credits to California taxpayers for investments into COIN-certified CDFIs. Each year, COIN is authorized to allocate a 20% tax credit, for a program maximum of \$2 million in tax credits on \$10 million of community development investment. Investors must place a minimum of \$50,000 on funds on deposit or in equity with a CDFI for 60 months at zero percent interest to qualify for the tax credit. Unused credits may be carried forward.

During 2011, COIN certified 26 investments in 11 CDFIs totaling \$23.58 million. These investments were made by 22 investors, including seven insurance companies that invested \$16.3 million. In contrast, only \$1.65 million investments were made in 2010.

CDFI	2010	2011
1. Clearinghouse CDFI	\$250,000	\$700,000
2. Community Commerce Bank		\$300,000
3. Impact Community Capital CDE, LLC		\$5,500,000
4. Impact Community Capital LLC		\$5,500,000
5. Low Income Investment Fund		\$9,000,000
6. Marin Workforce Housing Trust		\$200,000
7. Neighborhood Housing Services of Orange County		\$100,000
8. Northeast Community Federal Credit Union	\$100,000	
9. Northern California Community Loan Fund	\$50,000	\$50,000
10. Opportunity Fund Northern California	\$250,000	
11. Rural Community Assistance Corporation		\$415,000
12. Self-Help Federal Credit Union California Division	\$1,000,000	\$815,000
13. The Housing Trust of Santa Clara County		\$1,000,000
Total Investment	\$1,650,000	\$23,580,000
Total State Tax Credit	\$330,000	\$4,716,000

Office of the Ombudsman

The Office of the Ombudsman's primary function is to support the Department's commitment to serve, educate and provide the highest level of customer service to our consumers, insurers, agents, brokers, and public officials. The Ombudsman is responsible for ensuring that the Department makes available to the public all the resources within its authority and that complaints about Department staff or actions receive full and impartial investigation.

Beyond this role, the Ombudsman serves as the primary contact for legislative offices, initiates consumer reviews of cases upon request, serves as liaison to public inquiry requests, analyzes consumer issues data for legislative focus, spotlights on areas in

need of regulatory reform and carries out special projects to enhance Department communications and streamline operations.

In addition, the Ombudsman's Office administers the process and facilitates the Commissioner's appointments of members to serve on nine boards and committees. In 2011, there were total of 39 applicants and 16 appointments made by the Commissioner.

During 2011, the Ombudsman staff responded to 1,295 constituent requests for assistance, 324 legislative inquiries while closing and facilitating 1,198 public requests. Many call more than once, and are communicating with the Ombudsman on a regular basis to find out status and be updated on the current situation

Administrative Hearing Bureau

The Insurance Commissioner is authorized by statute to fulfill a regulatory role and an adjudicatory role. The Administrative Hearing Bureau ("AHB") supports the Insurance Commissioner in his adjudicatory role. Pursuant to provisions of the Insurance Code, the Insurance Commissioner is authorized to conduct evidentiary hearings on various insurance matters.

The AHB supplies administrative law judges ("ALJ") to conduct hearings authorized by the Insurance Code. In 2011, the AHB employed 4 full-time ALJs, one full time ALJ II supervisor, two legal secretaries, one office technician and one office assistant. As directed by a particular statute, the ALJs conduct formal or informal hearings under the Administrative Procedure Act ("APA"). The ALJs submit proposed decisions to the Commissioner in accordance with the APA and other controlling statutes or regulations. Upon written agreement, the ALJs will mediate disputes thereby avoiding the necessity of an evidentiary hearing. The AHB also is charged with overseeing the hearing calendar, hearing room reservations, the mandate files and the court reporter contract.

The matters heard at the AHB during 2011 include the following:

- appeals from decisions of the Workers' Compensation Insurance Rating Bureau or insurance carriers regarding application of the workers' compensation insurance rating system and plans (Ins. Code Sections 11737 and 11753.1),
- cease and desist matters relating to conduct of business by insurers, & violations of Commissioner's stop orders (Ins. Code Sections 106.1-1065.7 & 790.05)
- non-compliance matters to determine whether an insurer is in compliance with the Insurance Code and associated regulations
- prior approval of disputed rate change applications in Proposition 103 lines of insurance (Ins. Code Section 1861.05)

In 2011, the AHB opened 34 cases and closed 34 cases: ¹

Case Type	Opened	Closed
Non-Compliance	1	1
Order to Show Cause	0	1
Prior Approval	2	0
Workers' Compensation Appeals	31	32

¹The number includes case closures that occurred in 2011 on files that were opened during 2010.

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**COMMUNICATIONS *and* PRESS
RELATIONS OFFICE**

The Communications/Press Relations Office

The Communications and Press Relations Bureau (CPRB) coordinates and disseminates the Department's message and objectives to consumers, the industry, media and CDI staff. The effective delivery of this information, through a variety of tools and methods, ensures that all Department efforts contribute to the ultimate goal of creating the best consumer protection agency in the nation.

The function of the CPRB is to inform the state of California of the undertakings within the Department, as the Bureau studies trends, conducts research and identifies media issues which need to be addressed. The CPRB fosters relationships with important stakeholders, the insurance industry, state legislators, the Governor's Office, consumers and with CDI staff.

The CPRB also collaborates with the Community Relations and Consumer Services and Market Conduct Branches in performing a myriad of outreach campaigns regarding the Department's consumer programs and services. The Communications Office plays an integral role by serving as a positive liaison with the press (television, newspaper, internet and radio media) via press releases, phone calls, emails, twitter and press events. The primary responsibility of the CPRB is to deliver information which is crucial in representing the message of the Insurance Commissioner and the Department.

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ADMINISTRATION *and* LICENSING
SERVICES BRANCH

Administration and Licensing Services Branch

The Administration and Licensing Services Branch (ALSB) provides administrative support services to the California Department of Insurance (CDI), including budgets, accounting, business services, human resources, and information technology; as well as licensing services to insurance agents, brokers, adjusters, and other insurance producers. The Branch consists of the following divisions:

- Financial Management Division
- Human Resources Management Division
- Information Technology Division
- Licensing Services Division

Financial Management Division

The Financial Management Division (FMD) consists of the following three bureaus:

- **The Accounting Services Bureau (ASB)** is responsible for a full range of accounting functions including payables, receivables, revolving fund, cashiering, general ledger, security deposits, and gross premium and surplus line tax collection. Approximately \$2.3 billion in tax revenue was collected for Fiscal Year 2010-2011 to support the State's General Fund. ASB maintains centralized records of CDI's appropriations, financial activities, and cash flow to ensure effective management of CDI's financial affairs and to provide accurate financial reports to State control agencies.

- **The Budget and Revenue Management Bureau (BRMB)** consists of the Budget Office and the Administrative Systems Unit (ASU).

The Budget Office develops CDI's annual budget including the preparation and submission of all Supplementary Schedules required by the Department of Finance (DOF) for the development of the annual Budget; develops annual budget allocations for all programs; develops various hourly rates for cost recovery; and monitors expenditures and revenue collection during the fiscal year.

The ASU oversees/maintains CDI's Time Activity Reporting System (TARS); generates monthly expenditure and TARS reports; provides TARS training and technical assistance to all CDI staff; provides technical support to users of various fiscal systems including CALSTARS; establishes new program cost accounts, as appropriate; updates the cost allocation plan; and develops specialized financial-related management reports.

- **The Business Management Bureau (BMB)** is responsible for providing CDI administrative and management services in the areas of purchasing, contracting, facilities, records, forms, equipment, publications, and fleet management; mail and supply services at all three Headquarters offices; and services such as photo identification and security, transportation management, and disaster management planning.

Key FMD Accomplishments in 2011:

- **Workload Budget Change Proposal** – The Department was successful in getting legislative approval for partial restoration of the resources CDI lost under the prior Administration. These resources helped move CDI's budget closer to levels necessary to address workload backlogs and ensure robust consumer protection.
- **Majestic Insurance Company** – In April 2011, the Securities Unit worked with our Legal Branch, State Treasurer's Office (STO), financial institutions, and insurance companies to transfer a sizable number of securities as part of the Rehabilitation Plan for Majestic. We successfully executed the transfer requests in record time. This joint effort made a significant impact. Not only were the policyholders and claimants protected from any loss or payment delay, but more than 80 jobs were saved at the company's California offices.
- **Depositing Department Income** – The Cashiering Unit deposits and reports the Department's income. Income is received via check, credit card, and electronic fund transfer (EFT). For Fiscal Year 2010-11, the Cashiering Unit deposited over 60,000 checks for approximately \$125 million, over 160,000 credit card transactions exceeding \$22 million, and 10,000 EFT transactions for over \$2.2 billion.
- **Facilities Management** – BMB was instrumental in facilitating the merger of the Fraud Division and Investigation Division offices in both Valencia and San Diego thus reducing the Department's environmental foot print and rent obligations. Additionally, BMB was successful at negotiating lease renewals and tenant improvements in Benicia, Morgan Hill, and the Sacramento Headquarter facilities resulting in tens of thousands of dollars in rent savings.

Major Programs:

Tax Collection Program – One of FMD's functions is to ensure the timely processing of tax returns filed by insurers and surplus line brokers, and the timely collection and reporting of all appropriate taxes. The timeframes for remitting tax payments to CDI are monthly, quarterly, or annually depending upon the tax liability of each insurer/surplus line broker.

For the tax year 2010, ASB processed a total of 5,820 tax returns as follows:

INSURANCE TYPE	NUMBER OF ANNUAL TAX RETURNS	TAX RATE	LAW REFERENCE
Surplus Line	3,840	3%	CIC Section 1775.5
Property & Casualty	912	2.35%	CRTC Section 12202
Ocean Marine	571	5%	CRTC Section 12101
Life	440	2.35% or 0.5%	CRTC Section 12202
Title	22	2.35%	CRTC Section 12202
Home	13	2.35%	CRTC Section 12202
Health	22	2.35%	CRTC Section 12202
Total	5,820		

A 5-YEAR SUMMARY OF PREMIUM AND SURPLUS LINES TAXES COLLECTED BY THE DEPARTMENT OF INSURANCE FOR THE STATE OF CALIFORNIA

FISCAL YEAR	TAXES COLLECTED
2006/2007	\$2,167,242,000
2007/2008	\$2,170,752,000
2008/2009	\$2,109,639,000
2009/2010	\$2,262,588,000
2010/2011	\$2,307,752,000

CDI Budget:

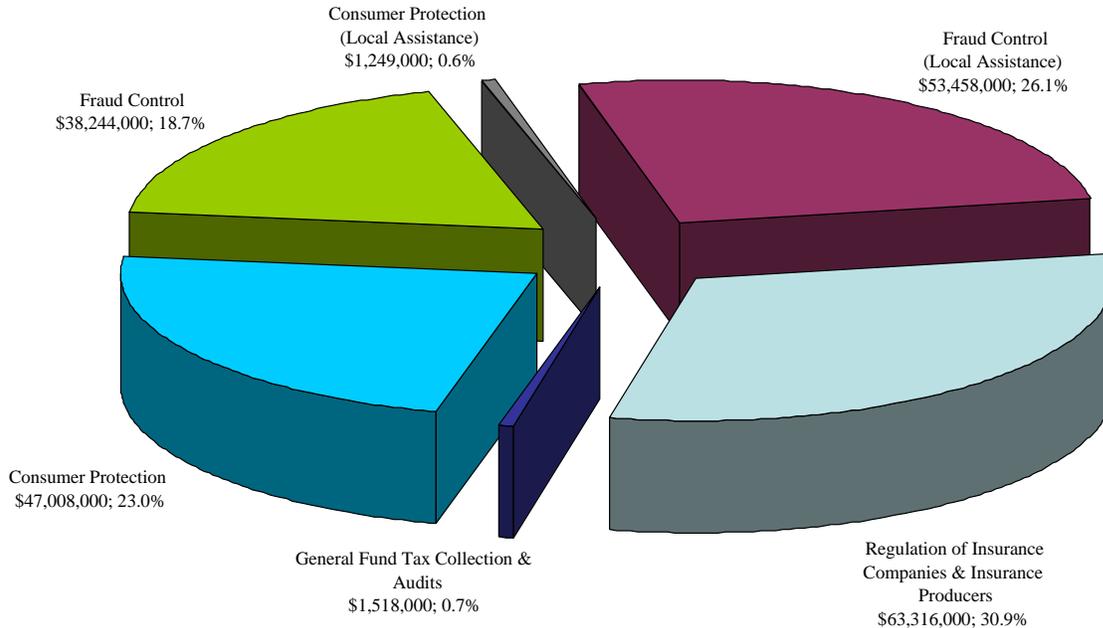
Programs – CDI's budget consists of the following four programs:

- **Regulation of Insurance Companies and Insurance Producers (Program 10)** – The objective of this program is to prevent losses to policyholders, beneficiaries, or the public due to the insolvency of insurers and to prevent unlawful or unfair practices by insurers and insurance producers.
- **Consumer Protection (Program 12)** – The objective of this program is to provide direct service to California consumers by protecting insurance policyholders and other parties involved in insurance transactions against unfair or illegal practices with respect to claims handling, rating, or underwriting by insurers, and to protect consumers from illegal and fraudulent practices in the sale of insurance.
- **Fraud Control (Program 20)** – The objective of this program is to protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and reduces the overall incidence of insurance fraud through anti-fraud outreach to the public, private, and governmental sectors. For the local assistance component, District Attorneys receive funding to implement the Organized Automobile Fraud Activity Interdiction program.
- **Tax Collections and Audits (Program 30)** – General Fund tax collection program performs tax collection, accounting, and tax audits of insurance companies and surplus line brokers. This program collected \$2.3 billion last year for the State's General Fund.

Expenditures – CDI's total expenditures for Fiscal Year 2010-11 were \$204,793,000. The graph on the next page displays the expenditures by program:

Regulation of Insurance Companies and Insurance Producers	\$63,316,000 (30.9%)
Fraud Control (Local Assistance)	\$53,458,000 (26.1%)
Consumer Protection	\$47,008,000 (23.0%)
Fraud Control	\$38,244,000 (18.7%)
General Fund Tax Collections and Audits	\$1,518,000 (00.7%)
Consumer Protection (Local Assistance)	\$1,249,000 (00.6%)
Total	<u>\$204,793,000</u>

**CALIFORNIA DEPARTMENT OF INSURANCE
TOTAL EXPENDITURES BY PROGRAM
FISCAL YEAR 2010 -11**



The following chart displays the expenditures by category:

CATEGORY	EXPENDITURE
Personal Services	\$106,264,000
Operating Expenses and Equipment	\$43,822,000
Local Assistance	\$54,707,000
TOTAL DISTRIBUTED	\$204,793,000

- **Personal Services** – Payments made for services performed by CDI staff to implement government programs. This includes salaries, wages and staff benefits.
- **Operating Expenses and Equipment** – This includes costs of goods and services (other than personal services previously defined) that are incurred by the CDI to support its operations.
- **Local Assistance** – Funds provided to local entities (e.g., District Attorneys) in support of CDI's programs.

Revenues – In Fiscal Year 2010-11, CDI generated \$197.9 million in revenue from fees, licenses, and various assessments paid by insurers, insurance producers, and other licensees. Insurance Fund receipts are generally received from the insurance companies and insurance producers that CDI services and regulates. Both insurers and insurance producers pay license, filing, and other fees. Insurance companies pay special assessments for Proposition 103, Workers' Compensation Fraud, Fraud Auto, and Fraud General. Insurance companies also pay for periodic examinations to determine the financial stability of the company and to evaluate insurance practices and market conduct.

TYPES OF REVENUE	AMOUNT	% OF TOTAL
License Fees and Penalties	\$33,262,000	16.8%
Fees, Examinations	\$19,524,000	9.9%
Fees, Proposition 103	\$23,758,000	12.0%
Fees, General	\$17,641,000	8.9%
Fraud Assessment	\$91,564,000	46.3%
Consumer Services (\$0.30)	\$8,767,000	4.4%
Life & Annuity	\$1,611,000	0.8%
Miscellaneous	\$1,797,000	0.9%
TOTAL, INSURANCE FUND REVENUE	\$197,924,000	100.0%

- **License Fees and Penalties** – This revenue is collected to cover the cost associated with the licensing and regulation of persons engaged in the business of insurance in California.
- **Examination Fees** – This revenue is collected to recover the cost of conducting financial and market conduct examinations to ensure that insurers are financially stable and operating in compliance with the CIC.
- **Proposition 103 Fees** – This is a voter-approved initiative that requires CDI to review and approve certain insurance rates. An annual assessment is levied to recover the actual costs incurred by CDI in administering the provisions of Proposition 103.
- **General Filing and Other Fees** – These fees cover the costs associated with processing and maintaining Action Notices, Policy Approvals, Insurer Certifications, Annual Statements, and Workers' Compensation Rate Filings.

- **Fraud Assessment** – This revenue was derived from the following assessments:
 - Workers' Compensation – The Fraud Assessment Commission determines the allocation of revenue. The Department of Industrial Relations collects the assessment from insurers and self-insured employers.
 - Fraud Auto – An annual fee of \$1.50 for each vehicle insured by an insurer is assessed. Part of the assessment collected is distributed to both the California Highway Patrol and to county District Attorneys.
 - Fraud General – An annual fee of \$2,100 to each insurer doing business in the State.
 - Fraud Health and Disability – An annual fee of \$0.10 that an insurer must pay for each person insured under a health or disability policy.
- **Consumer Services (\$0.30)** – An annual fee of \$0.30 for each vehicle insured by an insurer is assessed to fund consumer service functions of the CDI and improve consumer functions related to automobile insurance. Part of the fee (i.e., up to \$0.05) is specifically used to support the California Low Cost Auto Program.
- **Life and Annuity** – An annual assessment of \$1.00 per policy is levied on life and annuity insurers to fund various activities related to life and annuity, particularly investigation of misconduct and/or fraud of these insurers.

Human Resources Management Division

The Human Resources Management Division (HRMD) provides essential human resources support services to CDI's employees through the following five functional units:

- **The Classification and Pay (C&P) Unit** administers CDI's classification and pay program. C&P Analysts provide advice and assistance on varied and difficult personnel management problems; analyze and classify positions; gather and evaluate pay data; conduct classification or pay surveys; prepare formal memorandums or reports on personnel matters; participate in the presentation of such matters before the State Personnel Board (SPB) or other official bodies; investigate merit issue complaints within CDI; provide management support on employee progressive discipline issues; and review proposed personnel actions for conformity with regulations, classification and pay standards, and good personnel practices.
- **The Selections and Recruitment Unit** is responsible for CDI's selections process. The Selections Analysts administer civil service exams; conduct job analyses; establish certification and eligibility lists; oversee recruitment efforts; and function as liaisons between the SPB and CDI's programs in the development of online exams.

- **The Departmental Training/Health and Safety Unit** provides technical expertise, training, guidance, assistance, and support to employees, supervisors, and managers in administrative personnel matters relating to a variety of health and safety issues. The Health and Safety Analysts act as coordinators for the Family and Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), Reasonable Accommodation Policy (RA), Return-to-Work, Drug-Free Workplace Policy, the Workers' Compensation Program, the Health and Wellness Program, and perform ergonomic evaluations for CDI employees. The Training Officer/Analysts develop and deliver in-house training using instructor-led-training and Intranet-based training videos; coordinate training for Department employees; facilitate CDI's annual award and recognition programs; and administer the Biennial Language Survey and Workforce Development Training for CDI.
- **The Personnel Transactions Unit (PTU)** is responsible for processes and issues relating to personnel transactions in compliance with applicable Bargaining Unit Contracts/Memorandum of Understanding (MOU) language; CDI policies and procedures; Department of Personnel Administration (DPA) and SPB laws and rules; State Controller's Office (SCO) laws; and CDI management expectations. The Personnel Transactions Specialists prepare appointment, separation, and other personnel/payroll transactions documents to establish and update CDI employees' employment history and to ensure timely and accurate payment of regular and miscellaneous pay. The PTU staff ensure proper and timely completion of benefit forms and certify time and attendance to ensure accuracy of leave balances; disseminate HRMD policies, procedures, and personnel-related documents; develop methods, processes, and procedures on complex and diverse personnel practices designed to obtain consistency within HRMD and the CDI; and develop desk manuals, guidelines, memorandums and other forms of written communication and job aids to assist HRMD staff.
- **The Labor Relations Unit** facilitates cooperative and productive labor relations between CDI, its employees, and their respective employee labor organizations; establishes procedures for the equitable and peaceful resolution of differences on labor relations matters; and provides information on the implementation of collective bargaining agreements, including CDI policies and grievance responses.

Key HRMD Accomplishments in 2011:

- **Requests for Personnel Action (RPA) Processed** – HRMD received, reviewed, and processed nearly 900 RPAs for calendar year 2011, compared to 570 in 2010.
- **Actuarial Classifications** – HRMD, in collaboration with the Financial Surveillance Branch and Rate Regulation Branch, continues to lead a multi-department project to identify classification and compensation changes necessary to enable departments to recruit and retain qualified actuaries. Participating departments include the California Public Employees' Retirement

System, State Compensation Insurance Fund, California State Teachers' Retirement System, and the Department of Managed Health Care. Cooperative Personnel Services (CPS) HR Consulting has also been retained to assist in developing a package for submittal to DPA/SBP for consideration.

- **Progressive Discipline Function** – HRMD created a new consultant position specifically responsible for assisting supervisors/managers with constructive intervention and employee discipline issues. Additionally, a new Progressive Discipline Training Module for supervisors/managers was developed.
- **Classification Action Requests** – HRMD developed and submitted the following classification action requests to DPA. Each request consists of a classification analysis, an evaluation of comparable positions, a justification outlining what has changed to support the request, and a revised job description. All the requests submitted were approved by DPA.
 - CEA Level Change from a 1 to a 2 in the Licensing Services Division
 - New CEA 5 position in the Legal Branch
 - Exceptional allocation for new Labor Relations Manager I in HRMD
 - Exceptional allocation for a Staff Services Manager III in the Legislative Branch
- **Examinations and Job Analysis Reports** – SPB requires the completion of a job analysis report prior to the administration of an examination. A job analysis is valid for up to five years. If an exam for a classification is administered within five years, a new job analysis is not required. These reports not only provide for test validation, but also assist in recruitment, developing duty statements, identifying essential and critical skill functions, and/or medical related determinations regarding employment. This documentation is critical in order to defend exam processes and decisions, should they be challenged in court. Selections Analysts completed a job analysis on 13 different classifications during calendar year 2011.

Following is a list of the examinations developed and administered during the same year:

- **Examinations Administered—29:**
 1. Accounting Officer (Specialist)
 2. Associate Insurance Compliance Officer, DOI
 3. Associate Insurance Examiner
 4. Associate Insurance Investigator
 5. Associate Insurance Rate Analyst
 6. Associate Life Actuary (continuous exam)
 7. Associate Management Auditor
 8. Bureau Chief, Insurance Compliance, DOI
 9. Business Service Officer I (Specialist)
 10. Business Service Officer I (Supervisor)
 11. General Auditor III

12. Insurance Rate Analyst
 13. Legal Analyst
 14. Legal Support Supervisor I
 15. Program Technician III
 16. Property Controller II
 17. Research Analyst II (General)
 18. Research Program Specialist I
 19. Research Program Specialist II
 20. Senior Casualty Actuary (continuous exam)
 21. Senior Insurance Compliance Officer (Specialist)
 22. Senior Insurance Rate Analyst
 23. Senior Life Actuary (continuous exam)
 24. Staff Services Analyst (transfer exam)
 25. Supervising Fraud Investigator I
 26. Supervising Fraud Investigator II
 27. Supervising Insurance Compliance Officer
 28. Supervising Insurance Rate Analyst
 29. Supervising Program Technician III
- **CEA Examinations Administered—6:**
 1. Chief Actuary, Department of Insurance, CEA
 2. Chief, Field Examination Division, CEA 2
 3. Chief, Licensing Services Division, CEA 2
 4. Deputy Chief Counsel, CEA 5
 5. Deputy Commissioner, Administration & Licensing Services Branch, CEA 4
 6. Deputy Commissioner, Financial Surveillance Branch, CEA 4
 - **Training** – HRMD developed, coordinated, and facilitated New Employee Orientation Training for CDI employees who joined the Department within the last five years. The sessions were held in September and October 2011, and will be ongoing as necessary.
 - **Health and Safety** – HRMD’s Health and Safety Unit’s 2011 workload included the following:
 - Opened/processed 20 new Workers’ Compensation claims.
 - Closed 25 Workers’ Compensation cases.
 - Settlements were reached for four Workers’ Compensation claims.
 - Developed a Workers’ Compensation Claims Settlement Database to track CDI’s settlement rate and expenditures.
 - Received, evaluated, and resolved 28 reasonable accommodation requests.
 - Performed over 40 ergonomic evaluations for CDI employees.
 - Updated emergency plans for all CDI work sites, as well as recruited and trained new emergency team members.
 - Hosted five blood drive events.

- **CDI-Wide Biennial Language Survey** – The intent of the Dymally-Alatorre Bilingual Services Act (1973) is to provide for effective communication between all levels of government and the people of California who may be precluded from utilizing public services because of language barriers. The Act set forth specific requirements for State agencies to ensure provision of information and services to the public in the native languages of the non-English speaking people they serve. One of these provisions requires State agencies to conduct a biennial language survey and report to SPB by October 1 of every even-numbered year. The purpose of the survey is to inform the public the State agency serves of the languages spoken, and the bilingual resources that are available to ensure equal access. Another provision requires State agencies to provide an Implementation Plan (policy revision which identifies items such as who is responsible for the survey, how the agency recruits qualified bilingual staff, etc.) to SPB in every odd-numbered year. Based on the information gathered in the 2010 Biennial Language Survey, the 2011 Biennial Language Survey Implementation Plan for CDI was submitted to SPB and approved.
- **Annual Award Ceremonies** – In December 2011, award ceremonies were held in Los Angeles, Sacramento, and San Francisco to present the annual Employee Recognition Awards to CDI employees.
- **Employee Separation Notice** – The employee separation process was reviewed to address the issue of collecting outstanding monies owed by separating employees. The Employee Separation Notice HRM-0002 was revised to include Information Technology Division responsibilities, as well as to capture needed information to ensure timely and accurate separations of employees and note any monies owed the Department so that they are collected prior to the employee's separation date.
- **Lump Sum** – Procedures and processes were updated to ensure accurate processing of employee's lump sum payment at the time of separation. Checklists and a calculation worksheet were developed to assist staff in the computation of lump sum payments, and a review process was implemented for all separations.

Information Technology Division

The Information Technology Division (ITD) provides reliable, supportable, and innovative information technology (IT) solutions and services to the Department to achieve its business and operational requirements. The ITD consists of the following four bureaus:

- **Statewide Network Support Bureau (SNSB)** provides departmental support for the technology infrastructure. Support provided consists of telecommunication services, Local Area Network (LAN), Wide Area Network (WAN), hardware/software installation, email services, security, and maintenance for personal computers.

- **Application Development and Maintenance Bureau (ADAM)** provides custom software development and supports a variety of custom-off-the-shelf (COTS) products/applications to meet the business needs of CDI. ADAM is responsible for keeping abreast of the latest advancements in application tools and technology. ADAM monitors and maintains the Oracle Internet and Intranet application servers, commonly referred to as the 'middle tier', and works closely with the Office of Technology Services (OTECH) where CDI's production data is stored.
- **Project Coordination and Administrative Support Bureau (PCAS)** provides departmental and divisional support. Departmental support activities include IT procurement, IT project management, and control agency compliance. Divisional support activities include a wide range of administrative activities (e.g., division expenditure tracking, human resources coordination, IT and Department infrastructure budget tracking and monitoring, and training request coordination).
- **Web Services Bureau (WS)** is responsible for leading CDI's ongoing effort to institutionalize website accessibility and usability wherever CDI has a web presence. The Bureau is responsible for improving usability of CDI's website content and online services while ensuring compliance to State and Federal accessibility requirements. Also supported are the CDI's 141 content contributors and content managers responsible for the Internet and Intranet websites' content. The Bureau produces videos for CDI, which can be found on the Internet and Intranet websites.

Ongoing Major Operational Projects:

Paperless Workflow Project – The Paperless Workflow Project (PWP) implemented a technical and business infrastructure for an enterprise-wide system to support CDI's transformation to a paperless environment.

Implementation included:

- Install hardware and software to build the electronic document management system infrastructure.
- Implement an initial list of processes that demonstrate the range of capabilities including scanning, workflows, and integration with CDI's Internet presence to handle documents electronically.
- Develop the internal capability to convert more internal and external processes to paperless.

The scope of Phase 1 included automation of two forms and workflows; migration of documents into a central repository; replacement of one failing document management system; scanning, storing and managing paper and electronic files; and publishing files to the CDI Intranet according to CDI's business rules for five business processes.

The scope of Phase 2 included implementation of two case management systems; a document management system for CDI records that will be stored in the repository; implementation of document management tools such as redaction, version control,

allowing collaboration on documents, etc. for three CDI bureaus; and scanning and storage of closed case files.

The scope of Phase 3 includes implementation of two case management systems; implementation of three scan centers (Los Angeles, San Francisco, and Sacramento); development of forms, workflows, and data sharing; and a workflow and document management system.

A 2012-13 Budget Change Proposal was submitted to convert two limited-term ITD positions to permanent to support maintenance and operation of the PWP system.

Key ITD Accomplishments in 2011:

- **CDI's Website Named One of the Best in the Nation** – In 2011, CDI's website was named one of the best state-run insurance websites in the country for giving consumers access to critical insurance information. The recognition came from InsuranceQuotes.com, a website that provides thousands of consumers with a way to shop and compare insurance quotes online.

CDI's website is easy to navigate and effectively provides a way for consumers to perform such tasks as comparing auto insurance premiums, filing a complaint against an insurance company, or reporting insurance fraud.
- **2011 Digital Government Achievement Award** – CDI was recognized by the Center of Digital Government and awarded the Government-to-Business category for the Online Assistance System for Insurer Submittals (OASIS). The Digital Government Achievement Award highlights outstanding agency and department websites and applications. The award-winning OASIS was developed by CDI to allow insurance companies to submit application documents and financial data electronically through our website.
- **Independent Medical Review Website** – In collaboration with the Consumer Services and Market Conduct Branch, ITD created a website for the public to search for and display Independent Medical Review (IMR) decisions. An IMR is a process in which expert independent medical professionals are selected to review specific medical decisions made by an insurance company. CDI administers this program that enables an insured to request an impartial appraisal of medical decisions with certain guidelines specified by the law. The website allows the public to do searches, using specific data fields, and to print out reports.
- **Licensing Examination Vendor Replacement Project** – In collaboration with the Licensing Services Division and its vendor, ITD implemented a new computer-based examination service provider for exams given statewide to individuals who are applying for an insurance license.
- **Enterprise Wireless Networking** – ITD successfully designed, piloted, and began rollout for wireless networking in CDI's main and field offices. With an emphasis on security, the wireless network allows for mobility projects throughout the Department, including: 'hoteling' for mobile workforce staff (reducing office resources); guest access for vendors, consultants, trainers, etc.;

collaboration tools in conference rooms; denser field staff training for the Fraud and Investigation Divisions cutting down on travel costs; and iPads, tablets and other smart devices.

- **Commvault Backup Solution** – To protect CDI’s data assets, ITD completely overhauled the existing backup solution with a new state-of-the-art solution optimized for backup and recovery of data wherever it resides on servers in the main and field offices, in databases and applications, and in our expanding virtual environments. New technologies in de-duplication saves on overall storage costs, and new eDiscovery tools are available to quickly analyze and locate all data in CDI’s archives.

Licensing Services Division

The Licensing Services Division (LSD), under the authority of the California Insurance Code, protects insurance consumers and maintains the integrity of the insurance industry by determining the qualifications and eligibility of applicants for licenses. The Division consists of the following three bureaus:

- **Producer Licensing Bureau (PLB)** issues, maintains, and updates records of all insurance producer licenses; prepares and administers written qualifying insurance examinations; and reviews and approves education courses submitted by insurance companies, educational institutions, and others.
- **Licensing Background Bureau (LBB)** obtains information and documentary evidence regarding criminal convictions and other adverse actions in the backgrounds of insurance producers and licensing applicants seeking authority to transact insurance in California. LBB analyzes the evidence and makes recommendations as to the actions, if any, to be taken against these individuals.
- **Licensing Compliance and Company Investigations Bureau (LCB)** assists with the review and analysis of consumer complaint files received from the Investigation Division; performs background reviews of insurance company officers and directors; assists in processing the applications of non-admitted insurers applying to be added to the Department’s List of Approved Surplus Line Insurers; tests updated computer software systems; and maintains the producer licensing sections of the Department’s website.

Key LSD Accomplishments in 2011:

During 2011, LSD completed projects to enhance its examination process, improve consumer protection, improve operational efficiencies, and to achieve uniformity and reciprocity with other states’ licensing requirements.

- **Improved Licensing Examination Services** – Beginning in March 2011, PSI Services (PSI) began providing a wide range of license examination services to PLB for the purpose of improving customer service, improving the quality of its examinations, and streamlining the examination process.

For instance, in April 2011, PLB increased the number of examination sites available to license applicants from 4 to 18 locations statewide. Currently, more

than 50 percent of license applicants choose to take their examination at one of the new sites. All of the new sites provide free parking and most of these sites offer both evening and Saturday examinations.

Prior to the addition of the new sites, PLB found that the examinee to proctor ratio at the Department's examination sites was as high as 30-1. However, the addition of the new sites had the effect of reducing the number of examinees at the Department sites by 50 percent, which in turn reduced the examinee to proctor ratio to as low as 10-1.

In addition, PSI facilitated examination workshops that consisted of a review of questions from the Life and Health agent examination to ensure that the questions and answers are relevant, accurate, current and free of cultural biases. Subject matter experts from both the insurance industry and the Department participated in these workshops.

Further, PSI and the Department began collecting demographic data from the examinees. The demographic data, collected on a volunteer basis, includes gender, ethnicity, country of origin, and education level. PLB uses this data to assist in its analysis of the examinations' questions and answers.

Finally, the new sites resulted in a significant decline in enrollment at the Department's San Diego site, thus allowing CDI to achieve operational efficiencies by closing the site in November 2011.

- **Implemented Legislation** – PLB successfully implemented new legislation (AB 2782, Chapter 400, Statutes of 2010) for the purpose of improving consumer protection, improving operational efficiencies, and to bring California closer to uniformity with other states' producer licensing laws. These changes to the California Insurance Code took effect on January 1, 2011.

Specifically, the changes included: requiring property and casualty licensees who transact disability insurance to now also hold an accident and health license; recasting the fire and casualty broker-agent license to the property broker-agent and casualty broker-agent licenses; set the ethics training requirement for both independent and public insurance adjusters at three hours during each two-year license term and staggered the renewal dates for new applicants of these licenses; and finally, increased the license term for bail licensees from a one-year license to a two-year license.

Key Producer Licensing Statistics:

The following chart compares key producer licensing workload statistics between calendar years 2010 and 2011:

WORKLOAD	2010	2011	PERCENTAGE CHANGE
License Applications Received	65,757	70,432	+7%
License Examinations Scheduled	59,306	60,125	+1%
New Licenses Issued	46,431	61,053	+13%
Licenses Renewed	107,433	113,812	+6%
Insurer Appointments/Terminations	650,775	675,372	+4%
Bonds Processed	6,828	5,984	-12%
Licensing Calls Handled	147,666	133,275	-10%

License Information Required by the California Insurance Code:

Chapter 270, Statutes of 2007 (AB 720), added Section 1707.7 to the California Insurance Code to require annual statistics on several agent and broker licenses to be included in the Department's annual reports covering the years 2008 through 2012. To meet this mandate, the statistical information for 2011 is as follows:

(A) During 2011, the total number of applications received for the specified license types were as follows:

LICENSE TYPE	NUMBER OF APPLICATIONS
Property/Casualty Broker-Agent	15,088
Personal Lines Broker-Agent	4,614
Limited Lines Automobile Agent	1,083
Life and Accident/Health Agent	27,234
Life Agent	16,972
Accident/Health Agent	5,117

(B) During 2011, the total number of new licenses issued for the specified license types were as follows:

LICENSE TYPE	NUMBER OF NEW LICENSES ISSUED ¹
Property/Casualty Broker-Agent	10,829
Personal Lines Broker-Agent	3,711
Limited Lines Automobile Agent	697
Life Agent	28,302
Accident/Health Agent	23,135

¹ The number of new licenses issued in this table does include duplication, such as for those individuals issued a new license for a life agent license and also issued a new license for an accident and health agent license. Therefore, these numbers do not reconcile with the number of new licenses issued that is presented in the previous key licensing statistics table, which does not include duplication.

(C) The total number of licensed Life and Accident/Health Agents on December 31, 2011 was 214,795.

Key Licensing Background Statistics:

The following chart compares key licensing background workload statistics between calendar years 2010 and 2011:

WORKLOAD	2010	2011	PERCENTAGE CHANGE
Insurance agent and broker background reviews	3,796	3,878	2%
Cases referred to Legal Branch for disciplinary action	277	461	66%
Insurance agent and broker alternative resolution program cases	782	973	24%

Casework – LBB’s casework is derived primarily from these sources:

- PLB refers license applications wherein the applicant answered affirmatively to a background question in the application.
- The California Department of Justice (DOJ) provides ongoing criminal offender record information (CORI) on license applicants and current licensees based on fingerprints submitted during the initial licensing process. LBB checks both the Federal Bureau of Investigation (FBI) and DOJ level criminal history records

during the licensing process. PLB will not issue the license until the CORI results are received from both DOJ and FBI.

- The National Association of Insurance Commissioners (NAIC) provides daily reports on out-of-state administrative actions through its NAIC Regulatory Information Retrieval System (RIRS). The NAIC also sends alerts via the electronic warehouse attachment repository whenever a background change matter is reported to the NAIC by a licensee in California.

Key Licensing Compliance Statistics:

The following chart compares key licensing compliance workload statistics between calendar years 2010 and 2011:

WORKLOAD	2010	2011	PERCENTAGE CHANGE
Insurance company officer and director background reviews	535	575	7%
Reviews of tax penalty relief requests	39	54	38%
Updates to list of approved surplus line insurers	10	13	30%
Issued warning letters to agents and brokers found to have a minor violation of the California Insurance Code - brought into compliance	42	45	7%
No violation found to alleged minor violation of the California Insurance Code	13	6	-54%
Cases referred to Legal Branch or Investigation Division for disciplinary action or further investigation	23	6	-74%

Casework – LCB’s casework is derived primarily from these sources:

- Suspected minor violations of the California Insurance Code are referred to LCB by the Investigation Division (Complaint Intake Unit).
- CDI’s Corporate Affairs Bureau delegates to LCB the responsibility of conducting background reviews of officers and directors of insurance companies who apply for approval to do business in California.
- DOJ provides ongoing CORI data on insurance companies’ officers and directors through fingerprints submitted during the insurance company licensing process. LCB checks both the FBI and DOJ level criminal history records during the licensing process.

2011 ANNUAL REPORT
OFFICE *of* CIVIL RIGHTS

Office of Civil Rights (OCR)

The OCR's purpose is to ensure the Department of Insurance (CDI) is in compliance with Title VII of the Civil Rights Act of 1964, as amended, and the Fair Employment and Housing Act which prohibits discrimination and harassment of employees and applicants for employment on the basis of their protected status. To ensure these objectives are met, the OCR maintains and monitors compliance with the Department's discrimination and sexual harassment prevention policies and practices. The OCR ensures that all CDI staff are trained to comply with these policies, and practices in employment, development and treatment of its employees and the consumers that we serve.

It is the goal of the OCR to eliminate the harmful effects of discrimination, harassment and retaliation so employees can focus on the mission of the Department. The OCR has implemented a policy of handling all complaints internally, with the few exceptions where a conflict of interest may exist. This has encouraged a positive working relationship with staff at all levels within the CDI. The OCR continues to promote an open door policy to ensure that CDI employees feel comfortable knowing that they may contact the OCR about any issue at any time. This strategy can play a vital role in encouraging employees to report possible violations of the Department's policy to the CDI OCR first, thereby allowing the Department to address issues of concern before employees seek avenues outside of the Department. The OCR conducts approximately eight to ten counseling and management inquiries per week.

In August of 2010 the OCR began conducting mandatory "Discrimination and Sexual Harassment Prevention" training for supervisors/managers and rank and file staff. It was the goal to train on a two year cycle. That goal has been met and we are now conducting new employee and make up training sessions. To date, 100% of rank and file employees have been trained on reasonable accommodation. OCR will next focus on training for all supervisors and managers on their role and responsibilities in the reasonable accommodation process under the Americans with Disabilities Act and the Fair Employment and Housing Act.

The OCR is in the process of working with the Human Resources Division to update the CDI Reasonable Accommodation Policy that will be available for all CDI staff.

2011 ANNUAL REPORT

**ORGANIZATIONAL
ACCOUNTABILITY OFFICE**

Organizational Accountability Office

The **OAO** is the CDI unit that provides management of the Department with independent, objective, accurate and timely information necessary to make policy decisions. The OAO assists management in their efforts to increase operational and program efficiency and effectiveness by providing them with analysis, appraisals, recommendations, and technical assistance.

The OAO is independent and team-oriented, committed to providing timely, professional, and objective services to satisfy customer needs. The OAO takes personal responsibility for its work by meeting the standards of professional competence.

The OAO is composed of three distinct functions with six staff members reporting directly to the Chief Deputy Commissioner:

- Internal Audits Unit
- Business Process Reengineering Unit
- Ethics Office

Internal Audits Unit

The **IAU** was established in 1994 to ensure compliance with management's goals and objectives and adherence to federal, state, and departmental mandates, policies, and procedures. The professional audit staff conducts internal audits and special projects for the Department according to the International Standards of the Institute of Internal Auditors.

The audit staff assists executive management by conducting performance audits and program effectiveness and efficiency reviews. The staff facilitates a Department-wide Risk Assessment as well as the Financial Integrity and State Manager's Accountability Internal Control Review every two years. The staff also performs a variety of special projects that include: research and fact finding, project consultation, post-implementation evaluations, reviews of automated projects, reviews of proposed changes to policies and procedures, and participation in various workgroups.

The OAO owes a responsibility to management to provide information about the adequacy and effectiveness of the Department's system of internal controls and quality of performance.

Business Process Reengineering Unit

The **BPRU** was created in 2009 to provide pertinent and meaningful world-class solutions to the Department. Specifically, the Unit conducts preliminary Needs Assessments of each branch's business processes to identify resource requirements of the branch, and makes recommendations for the testing, implementation, and monitoring of proposed business process redesign efforts based on the individual Needs Assessments. As requested, the Unit performs in-depth comprehensive business process reviews of each branch; identifies problems or inefficiencies to

determine if branches are maximizing the resources and utilizing cost-effective and efficient business processes in the delivery of services to internal and external stakeholders; writes reports, presents alternatives and makes recommendations to management on methods to achieve improved business process efficiencies, and effectiveness for each business process. The Unit also works on a regular basis with all levels of CDI administration to resolve findings and observations resulting from compliance reviews, audits, and research by the internal audits unit. The BPRU provides formal training on business process efficiency and related topics to large groups of CDI staff, describing assigned program(s) operational requirements and potential improvements to efficiency and effectiveness.

Ethics Office

The **EO** was created in 2000 to provide private, secure, and confidential communications and investigations. The Office is intended to receive and research complaints and enquiries regarding employees' possible conflicts with the Political Reform Act and the Department's Incompatible Activities Statement, such as misuse of state property, inappropriate acceptance of gifts, and abuse of authority.

This is an independent office where the Department's employees can confidentially obtain answers to questions regarding proper conduct and report improper governmental activities by telephone, letter, or e-mail. The Office investigates claims of suspicious activities as required by the State Administrative Manual Section 20080. It oversees ethics orientation training for the Department's employees and advises them of their rights and responsibilities under the Whistleblowers' Protection Act.

2011 ANNUAL REPORT

CONSERVATION *and* LIQUIDATION
OFFICE

Conservation and Liquidation Office

Section 1 – The Conservation & Liquidation Office

Section 2 – Estate Specific Information

Section 3 – Cross Reference to California Insurance Code

Section 1 – The Conservation and Liquidation Office

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Background

The California Insurance Commissioner (“Commissioner”), an elected official of the State of California, acts under the supervision of the Superior Court when conserving and liquidating insurance enterprises. In this statutory capacity, the Commissioner is charged with the responsibility for taking possession and control of the assets and affairs of financially troubled insurance enterprises domiciled in California. An impaired enterprise subject to a conservation or liquidation order is referred to as an estate.

The Commissioner, through the state Attorney General’s office, applies to the Superior Court for a conservation order to place a financially troubled enterprise in conservatorship. Under a conservation order, the Commissioner takes possession of the estate’s financial records and real and personal property, and conducts the business of the estate until a final disposition regarding the estate is determined. The conservation order allows the Commissioner to begin an investigation that will determine, based on the estate’s financial condition, if the estate can be rehabilitated, or if continuing business would be hazardous to its policyholders, creditors, or the public.

If, at the time the conservation order is issued or anytime thereafter, it appears to the Commissioner that it would be futile to proceed with the conservation of the financially troubled estate, the Commissioner will apply for an order to liquidate the estate’s business. In response to the Commissioner’s application, the Court generally orders the Commissioner to liquidate the estate’s business in the most expeditious fashion.

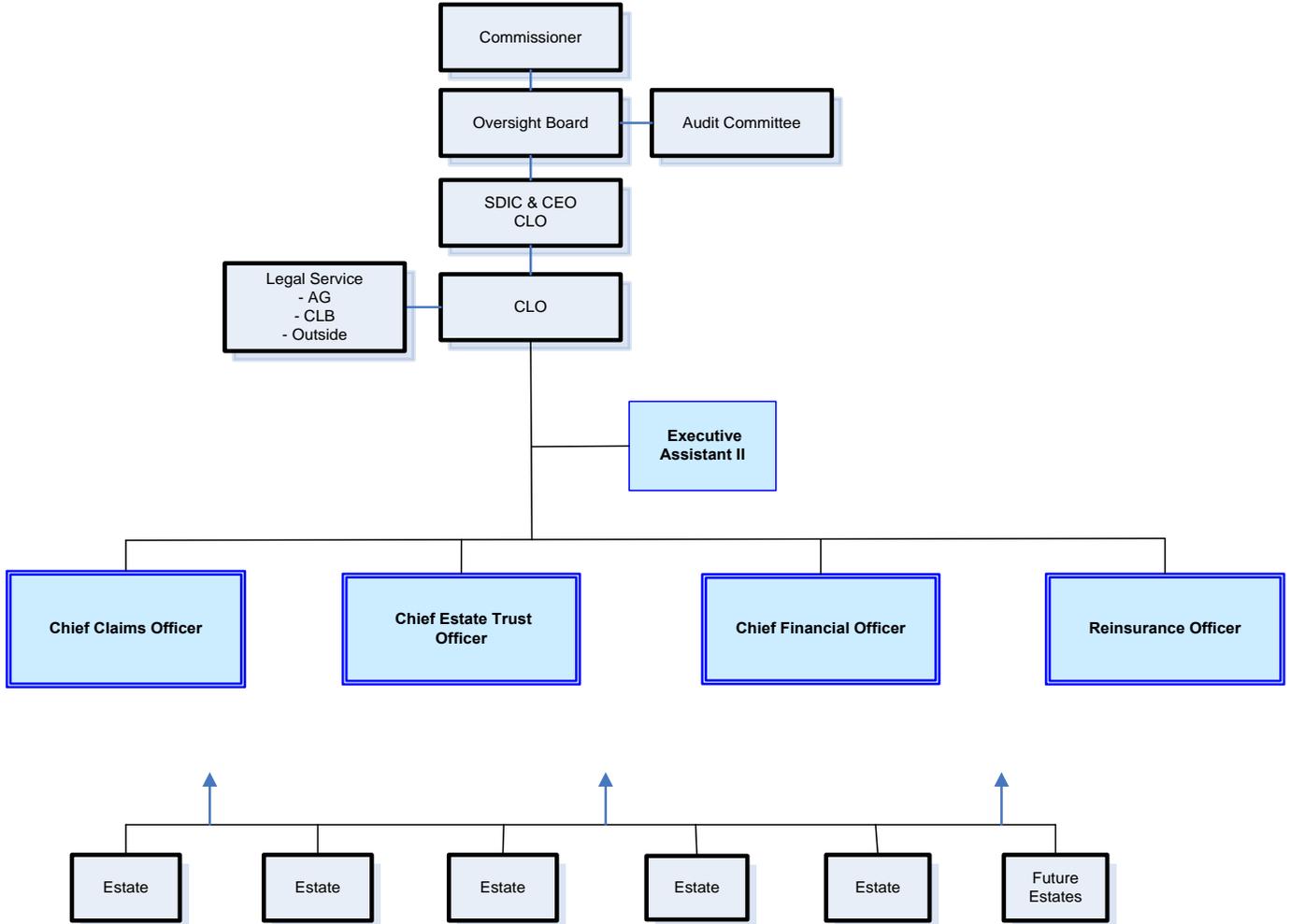
In order to discharge the Commissioner’s responsibilities as conservator or liquidator, the Commissioner appoints special deputy insurance commissioners as agents to act on his or her behalf. The Commissioner formed the Conservation & Liquidation Office (“CLO”) to fulfill the Commissioner’s responsibilities as conservator, receiver and liquidator.

The CLO was created in 1994 as the successor to the Conservation & Liquidation Division of the Department of Insurance. The CLO is based in San Francisco, California.

As of December 31, 2011, the CLO was responsible for the administration of 22 insurance estates.

Organizational Structure

Conservation & Liquidation Office



Oversight Board and Audit Committee Meetings

CLO activities are overseen by an Oversight Board composed of three senior executives of the California Department of Insurance, appointed to the Oversight Board by the Commissioner. The current Committee members are Ms. Nettie Hoge, Chief Deputy Commissioner, Mr. Adam Cole, Deputy Commissioner and General Counsel, Mr. Al Bottalico, Deputy Commissioner-Financial Surveillance, and Mr. Jonathon Finston, Deputy Commissioner for Corporate and Regulatory Affairs. The Committee meets on an at least quarterly basis throughout the year and members have a 100% attendance record.

During 2011, the Oversight Board and Audit Committee held four regularly scheduled meetings.

2011 Organizational Goals and Results

On an annual basis, the CLO prepares a Business Plan for the organization supporting the CLO Mission Statement. The Business Plan is then presented to the Oversight Board Committee for approval. The CLO’s Mission Statement is as follows:

On behalf of the Insurance Commissioner, the CLO acts to rehabilitate and/or liquidate, under court supervision, troubled insurance enterprises. The CLO operates as a fiduciary for the benefit of claimants, handling the property of the failed enterprises in a prudent, cost-effective, fair, timely, and expeditious manner.

The 2011 Business Plan was a continuation of the objectives of the 2010 Business Plan, focusing on estate closings and distributions, collecting/converting assets, evaluating claims and enhancing the operating efficiencies of the CLO.

Entering 2011, there were 22 open estates under management by the CLO. The open estates consist of 19 Property & Casualty Estates and three Life/Health Estates. The CLO goal in 2011 was to close three estates and distribute \$382 million.

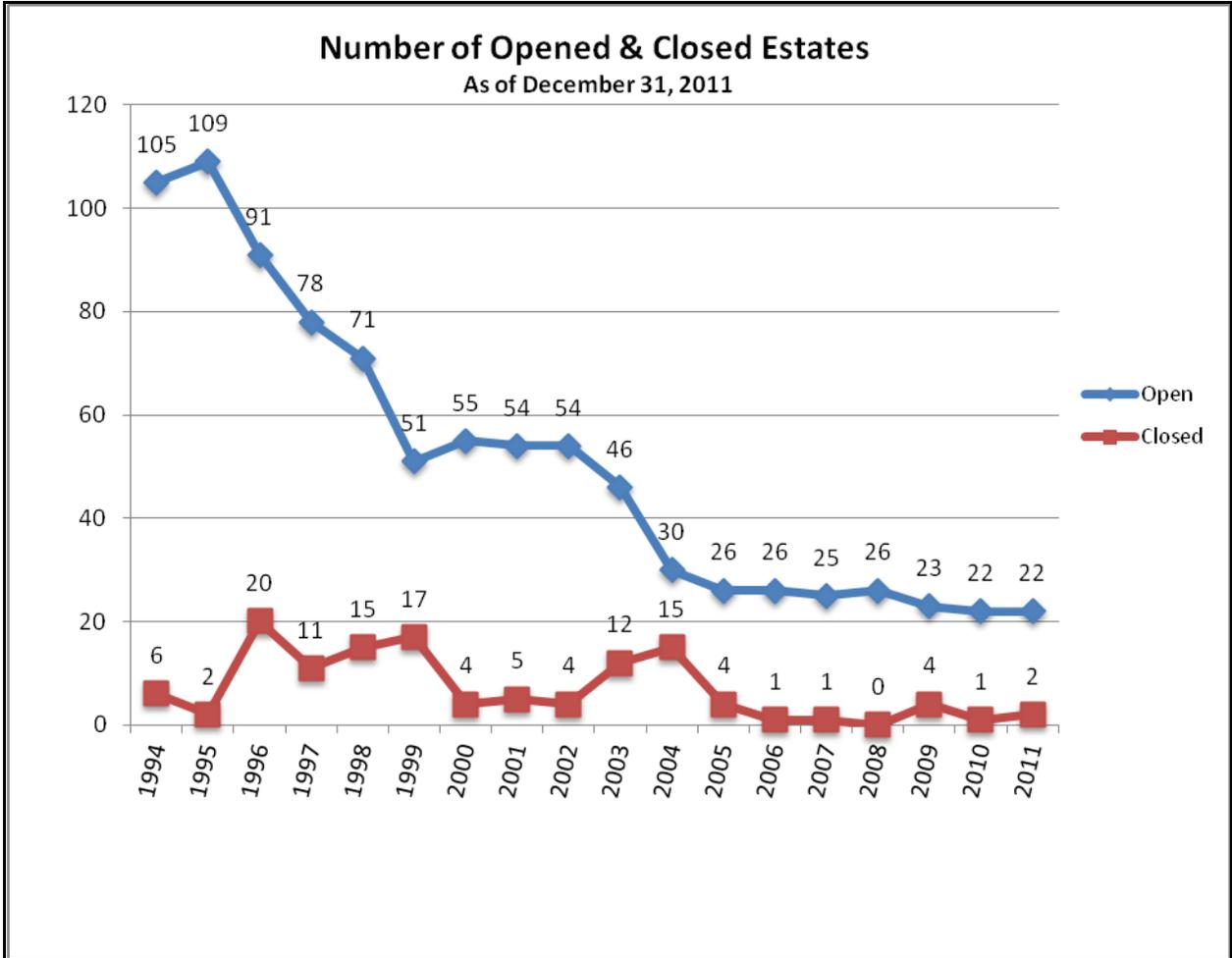
In addition to the Business Plan, there are individual work plans and cross-departmental estate teams for each estate. The individual Estate teams provide a written update on a quarterly basis.

The 2011 goals and results were as follows:

1. Closings

GOAL	RESULTS
<p>Close 3 Estates:</p> <ul style="list-style-type: none"> 1) Citation General 2) Municipal Mutual 3) Sable Ins. Co. 	<p>Two of the three estates were closed during 2011. One estate targeted for closure, Municipal Mutual, is scheduled to close during the first quarter of 2012.</p>

Number of Opened & Closed Estates as of December 31, 2011



Since 1994, there have been approximately 122 estates closed. These estates consisted of 55 ancillaries, 22 title companies and 45 “regular” insurers. Ancillary and title companies typically require only limited work on behalf of the Liquidator.

The chart above shows the number of Estates which have opened or closed each year from 1994 to 2011: 1994 – Opened 105, Closed 6; 1995 - Opened 109, Closed 2; 1996 – Opened 91, Closed 20; 1997 – Opened 78, Closed 11; 1998 – Opened 71, Closed 15; 1999 – Opened 51, Closed 17; 2000 – Opened 55, Closed 4; 2001 – Opened 54, Closed 5; 2002 – Opened 54, Closed 4; 2003 – Opened 46, Closed 12; 2004 – Opened 30, Closed 15; 2005 – Opened 26, Closed 4; 2006 – Opened 26, Closed 1; 2007 – Opened 25, Closed 1; 2008 – Opened 26, Closed 0; 2009 – Opened 23, Closed 4; 2010 – Opened 22, Closed 1; 2011 – Opened 22, Closed 2.

2. Distributions

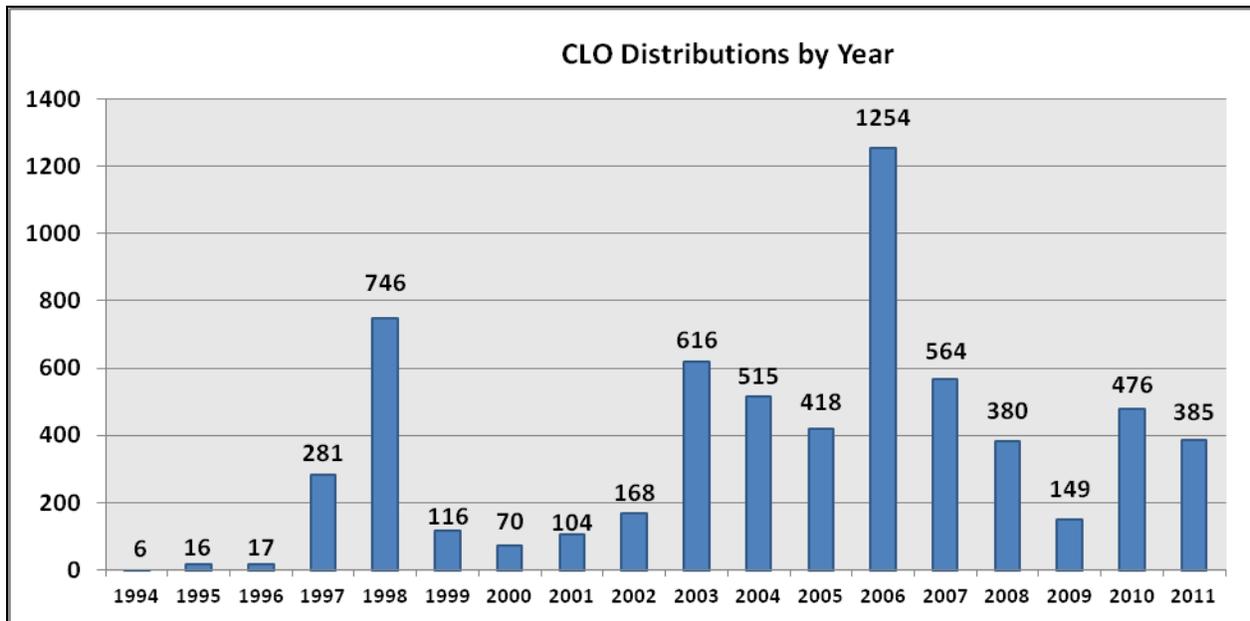
Early Access and Interim Distributions.

Distributions	2011 Actual (\$ Millions)	2011 Goal (\$ Millions)
SNICIL	\$253.9	\$240
Western Employers (stat deposit release)	\$1.2	\$0
Fremont Indemnity	\$39.9	\$60
HIH America	\$50.4	\$60
Pacific National	\$19.0	\$5
Sub-total:	\$364.4	\$365

Final Distributions

Distributions	2011 Actual (\$ Millions)	2011 Goal (\$ Millions)
Municipal Mutual	\$0.0	\$4
Enterprise	\$0.0	\$5
Sable	\$0.6	\$1
National Automobile*	\$0.8	\$1
Alistar	\$18.8	\$5
Paula*	\$0.2	\$1
Sub-total:	\$20.4	\$17
TOTAL DISTRIBUTIONS:	\$384.8	\$382

* Estate re-opened and closed within the current year to allow for a supplemental distribution of remaining monies



The chart above lists the CLO Distributions for each year from 1994 to 2011. The dollar amounts represented are in the millions:

1994, 6; 1995, 16; 1996, 17; 1997, 281; 1998, 746; 1999, 116; 2000, 70; 2001, 104; 2002, 168; 2003, 616; 2004, 515; 2005, 416; 2006, 1,254; 2007, 564; 2008, 380; 2009, 149; 2010, 476; 2011, 385.

CLO Investment Policy

The CLO has a formal investment policy, as approved by its Oversight Board, requiring that investments be investment grade fixed income obligations of any type. These investments may be issued or guaranteed by (1) the U.S. and agencies, instrumentalities, and political sub-divisions of the U.S., and (2) U.S. corporations, trusts and special purpose entities. Such securities must be traded on exchanges or in over-the-counter markets in the U.S. None of the portfolio will be invested in fixed income securities rated below investment grade quality by Standard & Poor's, Moody's, or by another nationally recognized statistical rating organization. In addition, the duration must be maintained within +/- 12 months of the Barclays Capital U.S. Government/Credit 1-3 Yr., which was 19 months at December 31, 2011.

The investments are managed in equal parts by two professional money management firms and are warehoused at the Union Bank of California.

At December 31, 2011, the CLO had \$593.5 million of estate marketable investment securities under management.

For the year ending December 31, 2011, the average portfolio balance was approximately \$741.5 million. The portfolio earned an interest yield of 2.6% and a net yield after security gains/losses and mark-to-market adjustments of 1.8%.

Administrative Expenses

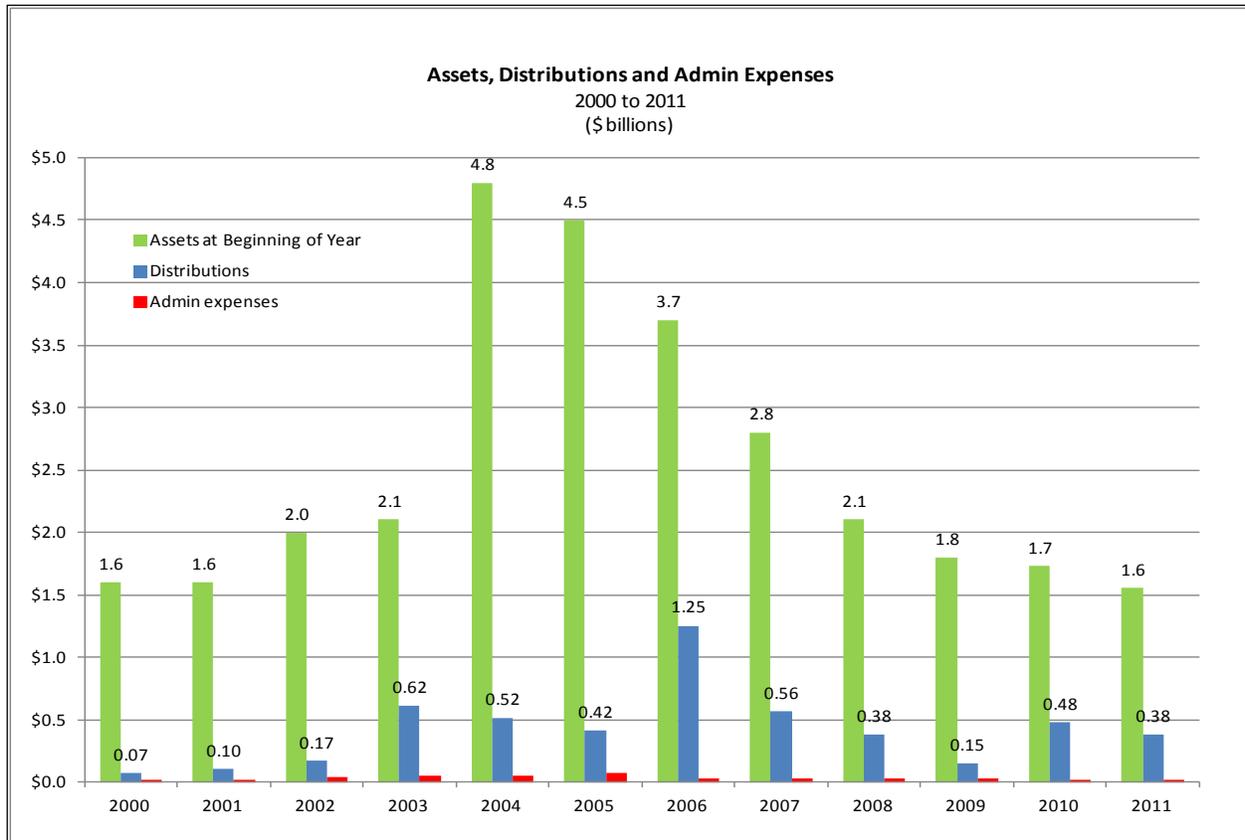
Administrative expenses consist of both direct and indirect expenses.¹

Direct expenses charged to estates consist of legal costs, consultants and contractors, salaries and benefits for employees working exclusively for a single estate, office expenses, and depreciation of property and equipment.

Indirect expenses that are not incurred on behalf of a specific estate are allocated using an allocation method based on the ratio of employee hours directly charged to a specific estate to total direct hours charged to all estates, and in some instances direct contract hours charged. For example, if employees charged 200 hours to a specific estate and in total 2,000 hours was incurred by all estates that specific estate would be allocated 10% (200 hours divided by 2,000 total hours charged to all estates). Indirect expenses include CLO employee compensation, rent and other facilities charges and office expenses.

In accordance with California Insurance Code Section 1035, the Commissioner may petition funds from a general appropriation of the State of California Insurance Fund if an estate does not have sufficient assets to pay for administrative expenses.

See "CLO Financial Results" section of this report on the budget and actual expenditures for 2011 for direct and indirect expenses.



The chart above displays the Conservation & Liquidation Office assets at beginning of year, distributions, and administrative expenses from the years 2000 to 2011. The table below lists these figures.

Year	Assets (\$ billions)	Distributions (\$ millions)	Admin. Expenses (\$ millions)
2000	\$1.6	\$70	\$21
2001	\$1.6	\$104	\$24
2002	\$2.0	\$168	\$40
2003	\$2.1	\$616	\$53
2004	\$4.8	\$515	\$50
2005	\$4.5	\$416	\$76
2006	\$3.7	\$1,254	\$32
2007	\$2.8	\$564	\$24
2008	\$2.1	\$380	\$29
2009	\$1.8	\$149	\$29
2010	\$1.7	\$476	\$22
2011	\$1.6	\$385	\$21

CLO Compensation

The CLO is not part of the State’s civil service system. All employees are at-will. The CLO does not have a bonus plan or pay incentive compensation. To that end, the CLO has established policies and procedures that are more akin to the private marketplace.

Compensation Methodology

The CLO engages an outside consultant to assist in establishing compensation ranges. In developing this report for the CLO, two published survey sources were used. These survey sources are described below:

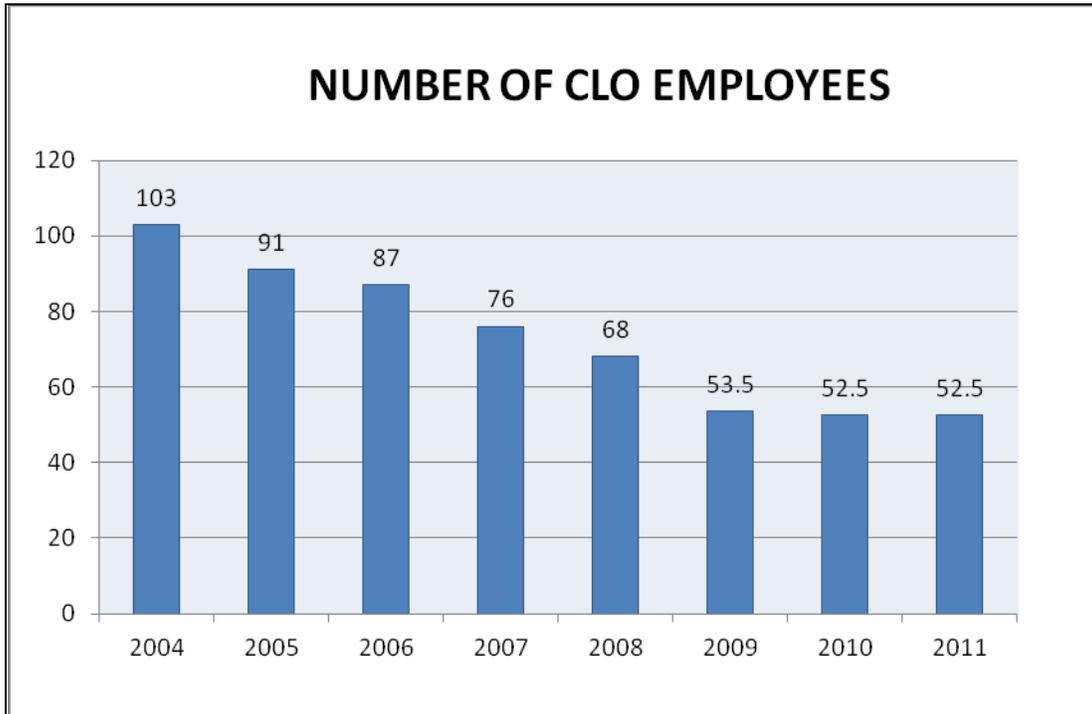
- Comp Analyst: Large survey representing thousands of companies across the U.S. which include hundreds of jobs. This subscription survey collects marketplace compensation data from many sources, and uses mathematical algorithms to predict the pay level of any of its survey jobs in major industries and geographical locations. The data used in this study was the nonprofit industry segment located in San Francisco.
- Economic Research Institute: Large survey representing thousands of companies across the U.S. which includes hundreds of jobs. This subscription survey collects marketplace compensation data from many sources and uses mathematical algorithms to predict the pay level of any of its survey jobs in major industries and geographical locations. The data used in this study was the nonprofit industry segment, organizations similar in size to the CLO, and located in San Francisco.

A summary of the compensation procedures follows:

- A written job description is developed for each position.
- Salary grades are derived from comparable external market data.
- Salary ranges are identified (low, middle, and high) based on market comparisons obtained by an outside independent compensation consultant.
- Salary ranges are updated periodically.
- The creation of a “new job position” is sent to an outside consultant for external evaluation.
- All employees receive an annual compensation review.

CLO employment and total salaries for employees are summarized below:

	31-Dec-11	31-Dec-12 (Budget)
Number of CLO employees at beginning of year	52.5	52.5
Total compensation and benefits for CLO employees	\$ 7,320,176	\$ 7,902,788



The chart above shows the number of CLO full-time employees from 2004 to 2011. 2004, 103; 2005, 91; 2006, 87; 2007, 76; 2008, 67.5; 2009, 53.5; 2010, 52.5; 2011, 52.5.

As estates have closed resulting in reduced workloads, and as a result of internal operating efficiencies, the number of full-time employees decreased by 51% compared to December 31, 2004.

CLO Financial Results

For Years Ended December 31, 2011 and December 31, 2010

Cash received	December 31, 2011		December 31, 2010
	Actual	Budget	
Litigation and reinsurance recoveries	\$195,829,200	N/A ²	\$553,998,900
Investment income, net of expenses	\$13,240,700	N/A ³	23,876,200
Total:	\$209,069,900		\$577,875,100

² Litigation and reinsurance recoveries are not susceptible to budgeting due to the irregular timing of their occurrence.

³ Investment income is not budgeted due to the large changes in investment balances that occur throughout the year, as well as changes in investment return rates.

	December 31, 2011		December 31, 2010
	Actual	Budget	
Distributions	\$384,770,000	\$382,000,000	\$476,114,600

Administrative – Estate Direct Expenses

Estate Direct Expenses	December 31, 2011		December 31, 2010
	Actual	Budget	
Legal expenses	\$7,937,700	\$11,227,800	\$9,202,000
Consultants and contractors	2,063,400	1,874,200	2,177,600
Office expenses	2,027,700	1,461,900	1,538,000
Compensation and benefits	116,500	0	80,100
Total	12,145,300	\$14,563,900	\$12,997,700

Administrative – CLO Overhead Expenses

CLO overhead expenses	December 31, 2011		December 31, 2010
	Actual	Budget	
Compensation and benefits	\$7,320,200	\$7,259,000	\$6,875,000
Office expenses	1,905,200	1,911,500	1,967,500
Consultants and contractors	167,800	174,000	185,500
Legal expenses	14,000	49,200	23,200
Total	\$9,407,200	\$9,393,700	\$9,051,200

Administrative Totals	December 31, 2011		December 31, 2010
	Actual	Budget	
Estate Direct Expense Total	\$12,145,300	\$14,563,900	\$12,997,700
CLO Overhead Expense Total	9,407,200	\$9,393,700	\$9,051,200
Total:	\$21,552,500	\$23,957,600	\$22,048,900

Estates Open Longer Than Ten Years

After the entry of an order placing an impaired California insurer into conservation and/or liquidation, the Insurance Commissioner and the CLO have the statutory responsibility to marshal and resolve the assets and liabilities of the failed entity.

The time required to close an insolvency proceeding is largely determined by the amount and complexity of the assets to be monetized and distributed to claimants. In addition, the length of an insolvency is equally affected by the amount of time required to make a final determination of an estate's liability.

Most of the insolvencies that remain open for more than ten years have some combination of on-going litigation; complicated tax exposure; potential collection of additional material assets; and challenges associated with the evaluation of liabilities. Until both sides of the insolvent estate's balance sheet are resolved (assets collected and liabilities fixed), the insolvency proceeding will remain open. In addition, estates are subject to federal tax reporting and escheatment requirements after the final distribution.

The estates listed below have been in liquidation for ten years or more.

Executive Life & ELIC Opt Out Trust:

Continuing asset recovery, via complex litigation, has required the Estate to remain open. The damages phase of the Commissioner's lawsuit against Altus has not been scheduled at this time. The Estate and associated trust will be required to complete any escheatment of unclaimed funds post-final distribution. Since the Estate was transferred to the CLO in 1997, the Estate has recovered \$731 million from litigation and distributed \$737 million to claimants. Assets presently in the Estate are held to fund ongoing litigation.

Frontier Pacific Insurance Company:

The Estate has an estimated \$18.3 million in current and future reinsurance recoveries as of December 31, 2011. These balances are due from approximately 29 reinsurers. Frontier Pacific is a difficult estate due to continuing issues with its NY parent ranging from comingling of data to the lack of cooperation. There are significant issues that will need to be resolved. Frontier Pacific's remaining reinsurance programs are labor intensive to administer, but known case reserves are relatively small. The Estate has scheduled an interim distribution in the second quarter of 2012 for approximately \$25 million.

Golden Eagle:

The Estate is in long-term run off. Although all policyholder claims have been 100% reinsured and policyholder claims are being paid timely, Golden Eagle remains liable to the policyholders should the reinsurer not be able to fulfill their obligations. The reinsurance program is structured to handle all remaining claims exposure. Until all claims are resolved or paid out, and all reinsurance collected, the Estate must remain open. The CLO acts in a pure monitoring capacity to ensure that the reinsurance structure continues to pay all claims.

Great States:

The Estate continues to seek a resolution on the AHA Surety Bond matter. The Estate continues to collect funds derived from the billings of paid workers compensation claims. The estate continues to rely upon CIGA for certain claim documentation to complete the billing to the surety. In an effort to resolve the remaining liability the parties will discuss updating certain actuarial studies and explore commutation possibilities. The balance of the remaining reinsurance program is in the commutation negotiation phase and requires certain releases from the participating guarantee associations. To date the Estate has distributed 40.3 percent of the paid losses to the Insurance Guarantee Associations.

HIH America Compensation & Liability:

The Estate's remaining reinsurance program involving upper layer treaties is being reviewed for potential collectability. The upper layer exposure has proven to be a challenge to negotiate and commute at a fair value with reinsurers, as evaluating the applicability of future penalty payments and reserves has been difficult. The Estate will await substantiation of the exposure and probability of recovery before booking the asset. To date, all Insurance Guarantee Associations have received a payment of 52 percent of their paid losses and the non-IGAs have received 45 percent of their approved claims.

Mission/ Mission National/ Enterprise:

All policyholder claims have been paid in full in accordance with the 2006 distribution plan. Significant reinsurance recoveries remain due to the estates from other insolvency proceedings. The estates continue to support the pending audit of the Covanta consolidated tax group. Upon conclusion of the audit and subject to the findings, the tax reserves will be released and distributed to remaining creditors. The Mission Trusts are working to submit disclosures to the Federal authorities seeking to identify and resolve any potential Federal claims associated with the policies issued by the Mission companies. The Mission Trusts suspended all distribution activity in 2011 and will continue to hold distributions until the estate has a more definitive determination of any Federal exposure to address. The Trusts are also assessing compliance requirements associated with policy coverage resulting in potential Medicare reporting obligations and identifying any continuing compliance issues.

Superior National Insurance Companies in Liquidation ("SNICIL"):

SNICIL resolved a long-term reinsurance dispute with U.S. Life in 2010, but there is another \$165,000,000 of collectible reinsurance still on the books. Nearly all of the collectible reinsurance involves long tail Workers Compensation business; thus, the strategy is to attempt to commute the remaining balances. This will continue to require a significant amount of time and effort to commute all of the reinsurance contracts and programs.

Western Employers:

Western Employers wrote coverage on very long-tail exposures (workers compensation, asbestos, tobacco, etc.) and has been subject to extensive litigation associated with claims that exceed state guaranty fund coverage limits or were altogether not covered by the guaranty funds. Inadequate record keeping and poor file management inherited at the time of liquidation have increased the difficulty in resolving the Estate's ultimate liability and collecting final reinsurance assets. There is also potential liability to the Federal Government. The process of resolving the government's claim, primarily that of the Environmental Protection Agency, has only recently begun.

Claims History

Property and Casualty Estates

Estate	Liquidation Date	Proof Of Claims Filed	Proof Of Claims Resolved	Open POCs
Alistar	10/24/2002	355	355	0
American Sterling	10/26/2011	TBD	TBD	TBD
Frontier Pacific	11/30/2001	43,573	43,570	3
Fremont	7/2/2003	45,663	45,345	318
Golden Eagle ⁴	2/18/1998		n/a (see below)	
HIH (2 estates)	5/8/2001	3,175	3,167	7
Majestic	n/a	17	0	17
Municipal Mutual	10/31/2006	14	14	0
Mission (3 estates)	2/24/1987	173,920	173,920	0
Pacific National	8/5/2003	4,448	4,447	1
Superior (5 estates)	9/26/2000	13,934	13,885	48
Western Employers	4/19/1991	9,809	9,399	410
	Total:	294,908	294,102	804

⁴ Golden Eagle is not subject to a finding of statutory insolvency. All claims are covered under a reinsurance agreement and are being paid by the reinsurer.

Life Insurance Estates

Executive Life Insurance Company: Executive Life is a life insurance company and has policies rather than claims. There were 327,000 policies/contracts.

Fremont Life Insurance Company: Fremont Life transferred approximately 3,500 in-force policies to assuming insurers via reinsurance agreements. All policy administration is handled by the successor insurers. The FLIC conservation estate is a wholly owned subsidiary of the Fremont Indemnity estate.

Golden State Mutual Life Insurance Company: Golden State transferred approximately 120,000 in-force policies to an assuming insurer via a reinsurance agreement. All remaining policy liability will be assumed by NOLGHA via consensual agreement subject to court approval in 2012.

2012 Business Goals

The 2012 Business Plan is a continuation of the objectives of the 2011 Business Plan, focusing on estate closings and distributions, collecting/converting assets, evaluating claims and enhancing operating efficiencies.

Entering 2012, there are 22 open estates under management by the CLO. The open estates consist of 19 Property & Casualty Estates and three Life/Health Estates. Our goal in 2012 is to close two estates and distribute \$111 million.

Starting 2012, we have 52.5 full-time employees and no temporary employees. We will re-assess staffing requirements at mid-year and will make any changes deemed necessary during the second half of 2012. In addition to the organizational goals, there are individual work plans and cross-departmental Estate teams for each of the 22 estates. The individual estate teams provide a written update on a quarterly basis.

The 2012 Goals are as follows:

2. Close 2 Estates⁵

- Alistar
- Municipal Mutual

⁵ Closing is defined as fully releasing the Commissioner from all legal responsibilities for an estate.

2. Early Access, Interim, and Final Distributions

Early Access Distributions:

Frontier Pacific.....	\$25,000,000
Superior National Estates	40,000,000
Fremont	40,000,000

Final Distributions:

Municipal Mutual.....	5,000,000
Fremont Life	<u>1,000,000</u>

\$111,000,000

Section 2 – Estate Specific Information

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• Current Year and Cumulative Distributions by Estate	205
• Estates in Conservation and/or Liquidation as of December 31, 2011.....	206
• Report on Individual Estates	207-249

Conservation or Liquidation Estates Opened During the Year 2011

American Sterling Ins. Co. – September 26, 2011

Majestic Ins. Co. – April 21, 2011

Conservation or Liquidation Estates Closed During the Year 2011

Citation General Ins. Co. – June 14, 2011

Sable Ins. Co. – July 26, 2011

Current Year and Cumulative Distributions by Estate (in \$000)⁶

Estate Name	Policy-holders	Year Ended 12/31/2011			Cumulative to 12/31/2011			
		Federal and State Claims	General Creditors	Total	Policy-holders	Federal and State Claims	General Creditors	Total
Alistar Ins Company	\$18,827			\$18,827	\$26,900			\$26,900
Citation General Ins Company					26,330		1,813	28,143
Executive Life Ins Company					737,276			737,276*
Fremont Indemnity Ins Company	39,906			39,906	902,361			902,361
Great States Ins Company					10,155			10,155
HIH America Ins Company	50,412			50,412	328,500			328,500
Mission Ins Company					846,833	111	265,664	1,112,608
Mission National Ins Company					499,852		27,077	526,929
Enterprise Ins Company					120,573	40	5,339	125,952
National Ins Company	781			781	24,209	14	3,877	28,100
Pacific National Ins Company	19,000			19,000	52,416			52,416
Paula Ins Company	209			209	139,213			139,213
Sable Ins Company	639			639	22,622			22,622
California Compensation Ins Company	194,424			194,424	840,908			840,908
Combined Benefits Ins Company	2			2	21,482			21,482
Superior National Ins Company	49,315			49,315	391,018			391,018
Superior Pacific Casualty Company	2			2	38,096			38,096
Commercial Compensation Casualty Company	10,134			10,134	93,984			93,984
Western Employers Ins Company	1,120			1,120	68,190			68,190
	\$384,771	\$0	\$0	\$384,770	\$5,190,918	\$165	\$303,770	\$5,494.853

⁶ American Sterling, Fremont Life, Frontier Pacific, Golden Eagle, Golden State Mutual, Majestic, and Municipal Mutual estates are not included on this schedule as no distributions have occurred.

* Since administration was transferred to CLO in 1997.

Estates in Conservation and/or Liquidation as of December 31, 2011

Estate Name	Date Conserved	Date Liquidated
Alistar Insurance Company	04/11/02	10/24/02
American Sterling Insurance Company	09/26/11	10/26/11
California Compensation Insurance Company	03/06/00	09/26/00
Combined Benefits Insurance Company	03/06/00	09/26/00
Commercial Compensation Casualty Company	06/09/00	09/26/00
Enterprise Insurance Company	11/26/85	02/24/87
Executive Life Insurance Company	04/11/91	12/06/91
Fremont Indemnity Company	06/04/03	07/02/03
Fremont Life Insurance Company	06/05/08	*
Frontier Pacific Insurance Company	09/07/01	11/30/01
Golden Eagle Insurance Company	01/31/97	02/18/98
Golden State Mutual Life Insurance Company	09/30/09	01/28/11
Great States Insurance Company	03/30/01	05/08/01
HHH America Comp. & Liability Insurance Company	03/30/01	05/08/01
Majestic Insurance Company	04/21/11	*
Mission Insurance Company	10/31/85	02/24/87
Mission National Insurance Company	11/26/85	02/24/87
Municipal Mutual Insurance Company	*	10/31/06
Pacific National Insurance Company	05/14/03	08/05/03
Superior National Insurance Company	03/06/00	09/26/00
Superior Pacific Casualty Company	03/06/00	09/26/00
Western Employers Insurance Company	04/02/91	04/19/91

**No Conservation or Liquidation Order obtained*

Report on Individual Estates

Each estate has its own unique set of challenges to monetizing assets, valuing the claims, distributing assets and closing. No two estates are the same. The remaining portion of Section 2 provides a brief summary of the 2011 operating goals and results, the current status of the estate in the conservation or liquidation process, and summarized financial information.⁷

In reviewing the financial information, the following must be taken into account:

- The Statement of Assets and Liabilities have been prepared on the liquidation basis of accounting. Under the liquidation basis of accounting, assets reported on the financial statements are assets that are determined to be collectible. The liabilities may change during the course of the liquidation depending on the types of business written by the company, and as claims are reviewed and adjudicated.
- No estimates for future administrative expenses are included in the liabilities, unless the estate has been approved for final distribution and closure by the Court.
- California Insurance Code Section 1033 prescribes that claims on estate assets are paid according to a priority, except when otherwise provided in a rehabilitation plan. The probability of a valid claim being paid is dependent on the valuation of the claim, the order of preference of the claim, and the amount of funds remaining after other claims having higher preference have been discharged. Each priority class of claims must be fully paid before any distribution may be made to the next priority class. All members of a class receiving partial payment must receive the same pro-rata amount.
- For estates where available assets are insufficient to pay all policyholder claims, the CLO intentionally does not evaluate the lower priority proofs of claims, since to do so would incur unnecessary administrative time and expenses, reducing funds available for distribution to higher-priority claimants.
- Shareholders receive any remaining residual value of the estate's net assets only after the general creditors have been paid.
- Beginning Monetary Assets at takeover represent cash and investment balances at the time of liquidation or, in cases where the estate was first liquidated and managed by other parties, at the time the estate was taken over by the Conservation & Liquidation Office.

⁷ *Estates under management of the CLO have an annual independent review of its financial statements. Copies of the independently reviewed financial statements can be accessed through the CLO webpage (www.caclo.org). Annual audits or reviews are waived for estates with little or no assets or activity.*

ESTATE SPECIFIC INFORMATION

Alistar Insurance Company

Conservation Order: April 11, 2002
Liquidation Order: October 24, 2002

2011 Report

Alistar Insurance Company (“Alistar”) was a non-standard automobile and workers’ compensation insurance company that was domiciled and wrote business in California. Alistar also wrote bail bond business, some portion of which was sold to Lincoln General Insurance prior to liquidation. The “Claims Bar Date,” or the final date to submit a claim against the insolvent insurer, was July 31, 2003.

The primary work associated with the insolvency was the transfer of all open covered claims to the California Insurance Guarantee Association (“CIGA”) and to run off the reinsurance program.

During 2011, the Estate’s goal was to complete a commutation settlement with the last remaining reinsurer and position the Estate to make its final distribution. All goals were satisfied and the estate completed its final distribution on October 19, 2011.

The Estate’s remaining objective is to escheat any unclaimed funds to the California Department of Insurance, and petition the San Francisco Superior Court to close the Estate in 2012.

Alistar Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$16,155,700	\$188,400
Recoverable from reinsurers	2,962,500	
Other assets	1,300	1,300
Total assets	19,119,500	189,700
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	8,900	9,400
Claims against policies, before distributions	48,409,600	37,595,900
Less distributions to policyholders	(8,073,200)	(26,899,800)
All other claims	111,000	111,000
Total liabilities	40,456,300	10,816,500
Net assets (deficiency)	(\$21,336,800)	(\$10,626,800)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$453,800	\$221,000
Salvage and other recoveries	366,800	9,300
Total income	820,600	230,300
Expenses	2010	2011
Loss and claims expenses	5,673,900	(10,654,800)
Administrative expenses	133,000	175,100
Total expenses	5,806,900	(10,479,700)
Net income (loss)	(\$4,986,300)	\$10,710,000

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$13,361,500
Recoveries, net of expenses	13,726,700
Distributions	<u>(26,899,800)</u>
Monetary assets available for distribution	<u>\$188,400</u>

American Sterling Insurance Company

Conservation Order: September 26, 2011

Liquidation Order: October 26, 2011

2011 Report

American Sterling Insurance Company (ASIC) is a California domiciled property and casualty insurance company formally located at 28202 Cabot Road, Laguna Niguel, CA 92677. ASIC is a wholly owned subsidiary of American Sterling Corporation (ASC), a California corporation. ASIC has a wholly owned subsidiary American Sterling Productions, Ltd, which in turn has four wholly owned subsidiaries, three that appear dormant and one that holds a material real estate investment.

ASIC is licensed to write multiple classes of insurance and is required to maintain a minimum capital and surplus of \$5.4 million. During 2010 ASIC wrote only liability and automobile classes of insurance in Arizona, Kansas and Nevada. ASIC is not writing business in California.

ASIC was placed under Supervision on August 1, 2011 pursuant to the Supervision Agreement between the California Insurance Commissioner (Commissioner) and ASIC. The supervision was the result, among other reasons, of recent cash flow concerns and the absence of liquid assets to ensure timely payment of claim obligations. Although ASIC reported capital and surplus of \$12,965,439 as of June 30, 2011, there were little to no liquid assets and the value of the investments in real estate, receivable from shareholder and mortgages were questionable. In addition, the California Department of Insurance (CDI) received a formal request from ASIC to allow an extension to the maturity of a \$7.5 million note from the primary shareholder. The note is being carried on the books at full value and is past due and ASIC is not receiving interest.

Due to a continuing lack of adequate cash flow to meet claims and overhead obligations, ASIC and its subsidiaries were placed into conservation on September 26th 2011. Control of the company was transferred to the Commissioner. After repeated assurances and promises from the company's CEO, no immediate prospect of new cash materialized. As a result, the conservator had to seek an insolvency order to trigger the state guaranty funds to honor current claims payments. ASIC and its subsidiaries were placed into liquidation on October 26, 2011.

As of December 31, 2011 all open claims had been transferred to the three participating IGAs, 30-day cancellation notices were issued at liquidation to all in force policyholders and insolvency orders were either served on key entities and principals or recorded in counties where ASIC or its subsidiaries have assets.

Proof of Claims were mailed to all known creditors with a claims bar date established at July 31, 2012.

The primary focus of the estate in 2012 is to monetize one or more of three highly illiquid assets and plan a distribution to the creditor group.

American Sterling Insurance Company

ASSETS AND LIABILITIES

As of September 30, 2011 and December 31, 2011

Assets	9/30/2011⁸	12/31/2011⁹
Cash and investments	\$104,500	(\$150,800)
Other assets	3,903,400	11,747,100
Total assets	4,007,900	11,596,300
Liabilities	9/30/2011	12/31/2011
Secured claims and accrued expenses	67,900	418,800
Claims against policies, before distributions	1,044,700	1,163,500
All other claims	269,200	276,700
Total liabilities	1,381,800	1,859,000
Net assets (deficiency)	\$2,626,100	\$9,737,300

INCOME AND EXPENSES

For Three Months Ended December 31, 2011

Income	2011
Investment income	(\$900)
Salvage and other recoveries	38,500
Total income	37,600
Expenses	2011
Loss and claims expenses	439,100
Administrative expenses	266,100
Total expenses	705,200
Net income (loss)	(\$667,600)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$104,500
Recoveries, net of expenses	(255,300)
Monetary assets available for distribution	<u>(\$150,800)</u>

⁸ 9/30/2011 figures are per quarterly statement filed with the California Department of Insurance using statutory basis of accounting.

⁹ 12/31/2011 figures are reported on a liquidation basis and reflect estimated recovery values for the states assets.

Executive Life Insurance Company

Conservation Order: April 11, 1991
Liquidation Order: December 6, 1991

2011 Report

Executive Life Insurance Company (ELIC) was placed in conservation by order of the Los Angeles County Superior Court on April 11, 1991. At the time, ELIC, which had more than 350,000 policyholders, was the largest life insurance insolvency in United States history. In the summer and fall of 1991, the Commissioner conducted an auction seeking bids to acquire the junk bond portfolio and insurance assets of ELIC. In December 1991, the Commissioner's selection of a group of French and European investors (the Altus/MAAF group) as the winning bidder, and the transaction was approved by the Conservation Court.

In March 1992, ELIC's junk bond portfolio was transferred to Altus Finance for a purchase price of approximately \$3 billion. In August 1993, the Court approved a final Rehabilitation Plan under which the majority of ELIC's assets and its restructured insurance policies were transferred to a new California insurance company created by the European consortium that had won the 1991 bid. The Rehabilitation Plan became effective in September 1993. Under the terms of the Rehabilitation Plan, former ELIC policyholders were given a choice either to accept new coverage (Opt In) from Aurora National Life Assurance Company (Aurora) or to terminate their ELIC policies (Opt Out) in return for a pro rata share of ELIC's assets. The Rehabilitation Plan also provided for the establishment of various trusts, collectively known as the Enhancement Trusts, to marshal and distribute assets for the benefit of former ELIC policyholders.

The Commissioner, in his capacity as conservator, rehabilitator and liquidator of the Estate, commenced a civil action in 1999 against Altus Finance S.A. (Altus) and other defendants alleging that they had acquired the junk bond portfolio and insurance assets of ELIC through fraud. Settlements were reached with Altus and some of the other co-defendants in 2004 and 2005.

A trial against the remaining defendant in 2005 resulted in a jury verdict finding Artemis S.A., a two-thirds owner of Aurora, liable for knowing participation in a conspiracy with members of the Altus/MAAF group to defraud the Commissioner. In August 2008, the jury's verdict of liability was upheld on appeal and the case was remanded to the U.S. District Court for a new trial on the issue of damages.

In January 2011, November 2011 and February 2012, the Commissioner's attorney filed a request for a trial setting conference but no trial was set. On April 2, 2012, the case was reassigned to a new judge, the Honorable R. Gary Klausner. The Commissioner's attorney filed a request for a trial-setting conference with Judge Klausner on April 9, 2012.

The Estate is a party to a proceeding brought by certain Indenture Trustee policyholders who challenged various CLO administrative expenses for the period January 1, 1997 to June 30, 2008. The Court issued an order on December 7, 2009 approving those expenses and subsequently denied the request by the Indenture Trustee policyholders for attorney's fees. On February 4, 2010, the Indentured Trustee Policyholders filed a

Notice of Appeal against the court's approval of CLO administrative expenses of ELIC for the period January 1, 1997 to June 30, 2008 (approximately \$12 million), as well as the court's denial of ITP's attorney fees of \$395,730.50. The ITP's appeal brief was filed in December 2010 and the Commissioner's response brief was filed January 27, 2011. The appeal matter has not been heard yet.

ELIC Opt-Out Trust

The Opt-Out Trust receives approximately 33% of ELIC assets which are distributed to approximately 27,300 former ELIC policyholders ("Opt-Outs") who elected to terminate their policies. A distribution of \$211 million of Altus Litigation Funds was made to Opt-Out policyholders in February 2006. Presently the remaining assets of the Opt-Out Trust consist of (1) distributions allocated to policyholders with whom contact has been lost, in most cases due to bad addresses (funds for those for whom contact has been lost will be escheated to the last known state of residence), and (2) the settlement proceeds of Mutuelle Assurance Artisanale De France ("MAAF") (one-third of the recovery of a default judgment in the name of defendant, MAAF) which became available for distribution to Opt-Out policyholders. As the costs to effect a distribution of this size outweigh the benefits to the Opt-Outs, the Commissioner determined that MAAF funds would be distributed when the new damages phase of the NOLHGA Premise including punitive damages, if any, is concluded. The trial court had initially set a trial date of November 3, 2009 but the court vacated that date with the understanding that a new trial date would be set. The Commissioner anticipated that if the trial was held on the date it was originally set, a distribution of the MAAF funds would have occurred together with any new awards that the Commissioner would have received. Because the date of the trial was vacated and a new date has not yet been set, the Commissioner moved forward and completed a distribution of approximately \$10 million of MAAF funds in September 2010. This trust however, continues to remain open to effect additional distributions to Opt-Out policyholders if the Commissioner is successful in the retrial.

FEC Litigation Trust

This trust was established September 1992 between First Executive Corporation ("FEC"), the parent company of Executive Life Insurance Company ("ELIC") and the Commissioner in his capacity as conservator, rehabilitator and liquidator of ELIC. The purpose of this trust was to collect the proceeds of certain litigation claims and to distribute the proceeds to former ELIC policyholders in accordance with the terms of the trust. The distribution in 2002 paid all funds except for funds that were due ELIC policyholders that could not be located. Those funds, where policyholders were unable to be located, were escheated to the various states of domicile. We have applied and have received approval from California Insurance Fund for a transfer of funds to reimburse the trust because of budget over-run. The trust is in position for closure by June 30, 2011. At that time the Commissioner will file an application, including financials from inception to close, to the court to terminate the trust and discharge the Commissioner as trustee. FEC closed on September 29, 2011.

Executive Life Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$46,208,200	\$39,882,000
Other assets	1,605,800	1,605,800
Total assets	47,814,000	41,487,800
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	8,835,200	8,013,000
Policyholders liability	5,696,985,700	5,924,618,100
All other claims	428,800	428,800
Total liabilities	5,706,249,700	5,933,059,900
Net assets (deficiency)	(\$5,658,435,700)	(\$5,891,572,100)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$1,245,400	\$708,100
Litigation recoveries		28,100
Miscellaneous income	650,500	
Total income	1,895,900	736,200
Expenses	2010	2011
Post-liquidation Federal income tax	(226,500)	
Administrative expenses	7,848,300	6,122,300
Interest on policyholders liability	227,623,300	227,750,300
Total expenses	235,245,100	233,872,600
Net income (loss)	(\$233,349,200)	(\$233,136,400)

CHANGE IN MONETARY ASSETS ¹⁰

Beginning monetary assets at takeover	\$112,111,400
Recoveries, net of expenses	665,046,500
Distributions	<u>(737,275,900)</u>
Monetary assets available for distribution	<u>\$39,882,000</u>

¹⁰ This schedule represents changes in monetary assets from August 1, 1997, when Executive Life's estate accounting was transferred to the CLO, to December 31, 2011.

ELIC Opt Out Trust

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$10,234,000	\$9,125,100
Total assets	<u>10,234,000</u>	<u>9,125,100</u>
Liabilities	12/31/2010	12/31/2011
Secured claims	7,568,800	6,662,500
Unclaimed funds payable	2,474,600	2,357,200
Reserve for administrative expenses	190,600	105,400
Total liabilities	<u>10,234,000</u>	<u>9,125,100</u>

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income and Expenses	2010	2011
Investment income	\$114,000	\$148,100
Administrative expenses	631,500	711,100
Net income (loss)	<u>(\$517,500)</u>	<u>(\$563,000)</u>

Fremont Indemnity Company

Conservation Order: June 04, 2003

Liquidation Order: July 02, 2003

2011 Report

Fremont was authorized as a multi-line Property & Casualty insurer, but at liquidation operated as a “Monoline” Workers’ Compensation insurer writing only Workers’ Compensation and Employer Liability coverage in 48 states. Fremont is the successor by merger of six affiliate insurers that were under the common ownership of Fremont Compensation Insurance Group, Inc. (“FCIG”), Fremont’s immediate parent company. FCIG is wholly-owned by a publicly traded holding company, Fremont General Corporation (“FGC”). Approximately 65% of Fremont’s Workers’ Compensation claims are attributable to business written in California. Most of the general liability business was assumed by a group of life insurance companies and administered through a third party administrator named Riverstone. The “Claims Bar Date”, or the final date to submit a claim against the insolvent entity, was June 30, 2004.

The Estate’s parent company, FGC, filed for protection under Chapter 11 of the federal bankruptcy code in June of 2008. As part of the FGC consolidated tax group the Estate sought to protect certain tax attributes and to ensure financial recovery or preservation of its net operating losses. Counsel for the estate filed four proofs of claims seeking recovery from the FGC bankruptcy estate. In April 2009 the Estate commenced global settlement discussions with representatives of FGC to settle all disputes between the Estate and FGC as it relates to the pending POCs. After months of negotiation the Estate agreed to settle all disputes in exchange for two approved, unsecured general creditor claims totaling \$40 million in approved voting claims that are capped at \$27 million in payout plus post-petition interest on \$5 million. In addition the estate received \$9 million in cash at execution of the settlement, and agreement with FGC to help facilitate the deconsolidation of the Estate from the consolidated tax group in a matter that allows the Estate to preserve all of its net operating losses for future application (estimated to exceed \$400 million).

All legal disputes have been resolved and essentially all amounts due under the global settlement with the FGC bankruptcy estate have been collected. The Estate has completed the deconsolidation process and is now a stand-alone taxpayer.

The Estate continues to bill and collect on active reinsurance treaties, as well as seeking commutations where advantageous. All on-going reinsurance processing is now being handled by the CLO San Francisco staff who will complete the balance of the run off of the reinsurance program.

The Estate released its seventh early access distribution in November 2011. The estate is planning an eighth early access distribution in 2012.

Fremont Indemnity Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$159,803,100	\$122,027,000
Recoverable from reinsurers	184,855,500	132,515,500
Other assets	25,781,300	25,215,600
Total assets	370,439,900	279,758,100
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	15,644,400	15,646,200
Claims against policies, before distributions	2,980,833,000	3,062,130,500
Less distributions to policyholders	(862,454,600)	(902,360,600)
All other claims	400,084,200	349,598,400
Total liabilities	2,534,107,000	2,525,014,500
Net assets (deficiency)	(\$2,163,667,100)	(\$2,245,256,400)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$2,998,100	\$2,331,900
Litigation recoveries	251,700	
Salvage and other recoveries	10,565,500	6,865,200
Total income	13,815,300	9,197,100
Expenses	2010	2011
Loss and claims expenses	210,327,300	87,285,700
Administrative expenses	3,938,200	3,402,100
Total expenses	214,265,500	90,687,800
Net income (loss)	(\$200,450,200)	(\$81,490,700)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover.....	\$434,855,900
Recoveries, net of expenses	589,531,700
Distributions.....	(902,360,600)
Monetary assets available for distribution.....	<u>\$122,027,000</u>

Fremont Life Insurance Company

Conservation Order: June 05, 2008

2011 Report

Fremont Life Insurance Company ("Fremont Life"), a California domiciled life insurance company was located in Costa Mesa, California and licensed in 13 states and Guam. Fremont Life is a wholly owned subsidiary of Fremont Compensation Insurance Group Inc., whose ultimate parent is Fremont General Corporation ("FGC"). FGC filed for protection under Chapter 11 of the U.S. Bankruptcy Code in June of 2008. On May 15, 2008, Fremont Life filed their March 31, 2008 quarterly statement with the California Department of Insurance reporting surplus of \$1,967,289. The minimum required capital and surplus for Fremont Life is \$4,500,000. With the subsequent bankruptcy filing by its parent FGC the California insurance regulators opted to seek a conservation of Fremont Life.

All active insurance contracts have been transferred to successor insurance companies, and the operations of Fremont Life have been discontinued. The conserved estate has the responsibility to ensure all risk associated with the remaining policies and life products are properly assumed by the successor insurers.

The Estate was able to recover most protective deposits in 2010, and is well under way to ensuring all risk has been transferred and novated. The Estate will seek to recover all remaining assets and to resolve all pending legal issues in 2012 and will work to close the conservation in late 2012 or early 2013.

Fremont Life Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$1,246,900	\$1,169,100
Other assets	159,300	159,300
Total assets	<u>1,406,200</u>	<u>1,328,400</u>
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	3,300	7,200
All other claims	1,435,000	1,336,200
Total liabilities	<u>1,438,300</u>	<u>1,343,400</u>
Net assets (deficiency)	<u>(\$32,100)</u>	<u>(\$15,000)</u>

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$73,400	\$19,600
Litigation recoveries		
Salvage and other recoveries	10,000	
Total income	<u>83,400</u>	<u>19,600</u>
Expenses	2010	2011
Loss and claims expenses	12,500	12,600
Administrative expenses	141,400	88,700
Total expenses	<u>153,900</u>	<u>101,300</u>
Net income (loss)	<u>(\$70,500)</u>	<u>(\$81,700)</u>

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$1,443,100
Recoveries, net of expenses.....	<u>(274,000)</u>
Monetary assets available for distribution	<u>\$1,169,100</u>

Frontier Pacific Insurance Company

Conservation Order: September 7, 2001

Liquidation Order: November 30, 2001

2011 Report

Frontier Pacific Insurance Company (“FPIC”), a California domiciled property and casualty insurer, was licensed in California, Nevada, New York and South Carolina. FPIC primarily wrote surety and private passenger auto liability. In August 2001, FPIC’s parent company, Frontier Insurance Company (“FIC”) of New York, voluntarily entered rehabilitation under the control of the New York Liquidation Bureau. As a result of the FIC rehabilitation, substantial reinsurance recoverables due FPIC from FIC were never paid. A subsequent financial examination by the California regulators disallowed the FIC reinsurance receivable, resulting in a negative surplus on FPIC’s books, and FPIC was placed into conservation on September 7, 2001. During conservation, the Commissioner determined that FPIC’s financial condition was such that rehabilitation was futile and an Order of Liquidation was obtained on November 30, 2001. The “Claims Bar Date,” or the final date to submit a claim against the Estate, was August 30, 2002. The FPIC claims operation was transferred to the CLO in October 2005.

FPIC and its agents (including its parent, FIC) held collateral in various forms as security for the issuance of surety bonds, including large numbers of bail bonds. The Liquidator has finalized and released security for those obligations which have expired. All items of collateral associated with bail bonds have been returned, except those associated with forfeited bonds. As for those outstanding unliquidated obligations, the Liquidator is making suitable arrangements to effect release to the appropriate parties, including escheatment. The Liquidator has reached an agreement with the New York Liquidation Bureau on a procedure for the disposition of collateral securing joint and several obligations of FPIC and FIC.

Since FPIC’s liquidation in November 2001, the liquidator continues to marshal FPIC’s assets to pay approved claims. In 2011, an arbitration proceeding against NICO, the main reinsurer of FPIC, not only awarded FPIC approximately \$18 million, but also preserved FPIC’s right to pursue a ULAE claim of approximately \$3.4 million. In light of FIC’s continuing inability to meet its full obligations to claimants, the New York court ordered FIC to submit a Rehabilitation Plan, which FIC plans to file in January 2012. The court invited all interested parties to file their objections to FIC’s proposed Rehabilitation Plan and also invited FIC to respond to all objections by April 2012. As an interested party, the Commissioner, on behalf of FPIC’s claimants, filed an objection and now awaits the court’s decision.

In the meantime, the Commissioner has filed an application with the California Liquidation Court to make an interim distribution of approximately \$25 million to FPIC’s claimants. The court has scheduled the hearing of the application for June 2012.

Frontier Pacific Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$18,270,900	\$33,725,200
Recoverable from reinsurers	40,358,200	18,318,300
Other assets	1,379,400	1,363,200
Total assets	60,008,500	53,406,700
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	2,810,000	3,656,600
Claims against policies, before distributions	53,847,100	44,077,000
All other claims	22,608,400	13,541,200
Total liabilities	79,265,500	61,274,800
Net assets (deficiency)	(\$19,257,000)	(\$7,868,100)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$512,800	\$ 254,000
Litigation recoveries		4,700,000
Salvage and other recoveries	118,100	83,400
Total income	630,900	5,037,400
Expenses	2010	2011
Loss and claims expenses	7,411,400	302,900
Post-liquidation Federal tax expenses	42,000	1,003,200
Administrative expenses	1,709,000	2,272,100
Total expenses	9,162,400	3,578,200
Net income (loss)	(\$8,531,500)	(\$1,459,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$18,531,900
Recoveries, net of expenses	15,193,300
Monetary assets available for distribution	<u>\$33,725,200</u>

Golden Eagle Insurance Company

Conservation Order: January 31, 1997
Rehab./Liquidation Plan Approved: August 4, 1997
Liquidation Order: February 18, 1998

2011 Report

Golden Eagle Insurance Company (“Golden Eagle”) is the subject of a Plan of Rehabilitation and Liquidation (“Plan”) approved by the Superior Court in 1997. Under the Plan, Golden Eagle’s operating assets and future business was sold to affiliates of Liberty Mutual Insurance Company. The Plan also provides for an orderly “run-off” of claims under Golden Eagle’s pre-1997 insurance policies, a process which is ongoing.

Prior to December 2006, the majority of the administrative aspects of the Plan were administered by the Golden Eagle Insurance Company Liquidating Trust (“The Trust”), which was created under the Plan and approved by the Superior Court as a neutral mechanism to manage the liquidation of Golden Eagle. Substantially all of the Trust’s duties were fully discharged by the end of November 2006, at which point the Trust was terminated and the residual liquidation duties were assumed by the Commissioner’s Conservation & Liquidation Office (“CLO”). The Trust was officially terminated and closed on November 30, 2006.

As part of the process for terminating the Trust, the Trust purchased additional reinsurance coverage from Liberty Mutual affiliates to cover the remaining covered insurance policy exposures, including liabilities under both workers’ compensation and other property and casualty policies. Because payment in full of Golden Eagle’s insurance liabilities are provided for under the Plan, the Liquidation Order does not contain a formal finding of insolvency, and thus the Insurance Guaranty Associations (“IGAs”) have not been triggered. As a result, no bar date has been set for the filing of insurance claims covered under a Golden Eagle policy. Such claims will continue to be received, adjusted and paid in the ordinary course of the run-off of Golden Eagle’s policyholder liabilities. The IGAs remain as a back-up, in the unlikely event that the claims payment assets available under the Plan are exhausted prior to the final policyholder claim payment.

Prior to its termination, the Trust was responsible for the management of the third-party claim administrator and reinsurer (affiliates of Liberty Mutual Insurance Company) that were and continue to be responsible for the adjustment and payment of covered policyholder claims under the Plan. Those oversight duties now reside with the CLO. The Trust also managed the residual assets of the Estate and administered to resolution all proofs of claims filed by general creditors. The “Claims Bar Date,” or the final date to submit general creditor claims (i.e., non-policyholder claims) against the Estate, was February 27, 1998. The adjustment and payment of non-policyholder claims was completed by the Trust shortly before the Trust termination near the end of 2006.

All remaining policyholder claims are being administered and paid under the Plan’s indemnity reinsurance agreement with Liberty Mutual affiliates. Given the “long-tail” nature of the claims portfolio, completing the run-off process is expected to take many more years. During 2011, the CLO continued negotiations with Liberty Mutual regarding

a possible transfer of the remaining run-off claims via novation or the equivalent in order to allow the Commissioner to close the Estate. Claims continue to run off within the range of expected cost and reinsurance coverage. Until the entire remaining exposure is paid, assumed or novated, the Estate must remain open to monitor the long-term claim run-off.

Golden Eagle Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$1,888,700	\$ 1,958,600
Total assets	1,888,700	1,958,600
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	900	400
Total liabilities	900	400
Net assets (deficiency)	\$1,887,800	\$1,958,200

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$58,200	\$31,500
Salvage and other recoveries		132,700
Total income	58,200	164,200
Expenses	2010	2011
Post-liquidation Federal tax expense		4,000
Administrative expenses	93,900	89,800
Total expenses	93,900	93,800
Net income (loss)	(\$35,700)	\$70,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover ¹¹	\$2,029,000
Recoveries, net of expenses.....	(70,400)
Monetary assets available for distribution	<u>\$1,958,600</u>

¹¹ As of December 31, 2006, when Golden Eagle's estate accounting was transferred to the CLO.

Golden State Mutual Life Insurance Company

Conservation Order: September 30, 2009

Liquidation Order: January 28, 2011

2011 Report

Golden State Mutual Life Insurance Company, (Golden State), was a mutual life and health insurance company domiciled and incorporated in California, with its principal place of business and home office located at 1999 West Adams Boulevard in Los Angeles, California. Golden State's business focus has been to provide life insurance products to the minority middle-income marketplace with a geographic emphasis in California, Texas, North Carolina, Michigan and Illinois.

As of June 30, 2009, Golden State filed its Quarterly Statement reporting assets of \$93,291,509 and liabilities of \$91,640,816. Thus, Golden State's surplus was \$1,650,693 or \$3,349,307 less than the total aggregate of the minimum paid-in capital and minimum surplus required by the Insurance Code. Consequently, Golden State was deemed statutorily impaired and placed into conservation on September 30, 2009.

The Conservator determined that the best course of action for Golden State's policyholders and creditors was for the Conservator to position Golden State for a sale, merger or an assumption of its insurance book of business by a third party.

In November 2009, the Conservator conducted a national "request for proposal" process seeking a healthy successor insurer to purchase the mutual company or assume its book of business. IA American Life Insurance Company was the successful bidder and the Superior Court approved IA's assumption of all in-force GSM policies sale on June 24, 2010.

By December, 2010 the Conservator had determined that it would be futile to proceed as Conservator since Golden State's estimated liabilities of \$9,291,895 exceed its estimated remaining assets of \$5,721,154 by over \$3 million. A hearing on the Liquidation Motion and an Order to Show Cause why the Court should not grant the Liquidation Motion was held on January 28, 2011, and an order of insolvency was granted.

During 2011 Golden State obtained court approval and completed the transfer of the company's pension plan obligation and administration to the Pension Benefit Guaranty Corporation. After quantifying approximately \$2 million in un-assumed Class 2 policy liability (convertible Group Life & LTD coverage for former employees and dependents), the estate negotiated an agreement with the National Association of Life and Health Guaranty Association (NOLGHA) whereby all un-assumed policy liability will be honored by the respective state guaranty association subject to any statutory limitations. As of December 2011 the form of replacement policy and rate structure for any excess coverage elections was still being reviewed by the CDI. Upon final approval of the form of policy and the rate schedule the estate will seek a court order authorizing the agreement and transfer of the liability.

Due to a continuing lack of available funds to distribute the estate filed a request with the court to suspend the formal proof of claim process and to extend the planned claims

bar date by 12 months. The court granted a new claims bar date of December 31, 2012. The estate will revisit the POC process and bar date in June of 2012.

The Estate sold the Dallas & Detroit district offices and placed Houston and Winston Salem properties under contract subject to court confirmation during 2011. The Chicago property was placed under contract but later terminated due to the buyer's concerns over certain underground storage tanks located near the property. The Chicago property is subject to an indemnification agreement with the oil company responsible for the underground tanks. The estate is pursuing a claim under the indemnification agreement. The last property in Vallejo continues to be listed on the open market.

The liquidation estate continues to defend its ownership and control over the two paintings currently located in the lobby of the former GSM building in Los Angeles. The landlord and owner of the building has been granted relief by the liquidation court to pursue its quiet title claim to the art works. The owner asserts the paintings are fixtures of the building, the liquidator argues the paintings are personal property of the estate. As a positive gesture to the local community, the estate has loaned a significant portion of the remaining GSM art collection (excluding the lobby paintings) to the California African American Museum as part of their Places of Validation exhibit. The same pieces will remain at the museum through early 2013 as part of a GSM exhibit.

Golden State Mutual Life Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$1,592,700	(\$147,000)
Recoverable from reinsurers		
Other assets	2,537,400	2,017,900
Total assets	4,130,100	1,870,900
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	1,618,800	591,400
Policyholder claims		2,212,900
All other claims	7,569,100	7,569,000
Total liabilities	9,187,900	10,373,300
Net assets (deficiency)	(\$5,057,800)	(\$8,502,400)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income (loss)	(\$605,400)	(\$4,100)
Cessions and premium income	15,707,200	148,600
Other income	1,070,200	34,300
Total income	16,172,000	178,800
Expenses	2010	2011
Loss and claims expenses	7,034,000	(203,300)
Administrative expenses	13,412,200	1,617,800
Total expenses	20,446,200	1,414,500
Net income (loss)	(\$4,274,200)	(\$1,235,700)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$72,139,200
Recoveries, net of expenses	(72,286,200)
Monetary assets available for distribution	<u>\$147,000</u>

HIH America Comp. & Liability Insurance Company

Conservation Order: March 30, 2001

Liquidation Order: May 8, 2001

2011 Report

HIH America Compensation Liability Insurance Company (“HIH”) was domiciled in California and licensed to transact business in 31 states with California being the primary state accounting for 82% of the business written. HIH wrote only workers’ compensation insurance. The “Claims Bar Date,” or the final date to submit a claim against the insolvent Estate, was December 2, 2001.

Given the number of states in which HIH wrote business, a significant effort was required at the time of liquidation to properly transfer all open covered claims to the insurance guaranty community. The Estate had a significant amount of intercompany relationships with various affiliates that required a considerable amount of work to resolve such intercompany balances. Additionally, the Estate had a significant reinsurance program that was placed under a run off plan.

The reinsurance program has been essentially run-off to conclusion with the exception of an upper layer treaty being analyzed for potential future recoveries. All material assets have been collected or resolved and the Estate completed a \$50 million interim distribution in December 2011. The Estate continues to collect periodic claim payments from the insolvency estate of its parent company and will work to schedule a final distribution and closing in 2012.

HIH America Comp. & Liability Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$62,555,300	\$ 12,816,700
Recoverable from reinsurers	1,507,100	1,434,600
Other assets	100	
Total assets	64,062,500	14,251,300
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	100	71,800
Claims against policies, before distributions	748,525,900	763,878,800
Less distributions to policyholders	(278,087,900)	(328,499,900)
All other claims	927,500	927,500
Total liabilities	471,365,600	436,378,200
Net assets (deficiency)	(\$407,303,100)	(\$422,126,900)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$1,878,800	\$970,600
Salvage and other recoveries	1,420,200	1,599,900
Total income	3,299,000	2,570,500
Expenses	2010	2011
Loss and claims expenses	38,868,500	16,951,300
Administrative expenses	262,300	473,800
Total expenses	39,130,800	17,425,100
Net income (loss)	(\$35,831,800)	(\$14,854,600)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover.....	\$147,637,800
Recoveries, net of expenses	\$193,678,800
Distributions.....	(328,499,900)
Monetary assets available for distribution.....	<u>\$12,816,700</u>

Great States Insurance Company

Conservation Order: March 30, 2001

Liquidation Order: May 8, 2001

2011 Report

Great States Insurance Company was domiciled in California and was licensed to transact business in 14 states. Great States wrote only workers' compensation insurance and concentrated in Arizona, Colorado, and Nevada. Great States wrote a minimal amount in California and Illinois. The "Claims Bar Date," or the final date to submit a claim against the Estate, was December 2, 2001.

A significant portion of the Estate's statutory deposits are held in the form of surety bonds and are released as claims arise and formal awards are issued. The entity that has issued the surety bond has off-set rights related to certain reinsurance recoveries by Great States. The process of reconciling these releases and offsets has been an on-going requirement of the Estate.

The Estate continues to seek a resolution of the surety bond issue with American Home Assurance. Absent an agreement on the development of loss reserves, the Estate will consider foregoing a settlement and seek agreeable arrangement with the California Guarantee Association to assign the surety bonds and prepare the Estate for a final distribution in 2012.

Great States Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$ 7,163,500	\$ 7,083,000
Recoverable from reinsurers	10,590,600	18,326,300
Total assets	17,754,100	25,409,300
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	48,000	39,200
Claims against policies, before distributions	85,178,400	85,630,100
Less distributions to policyholders	(10,154,800)	(10,154,800)
All other claims	11,917,600	14,659,700
Total liabilities	86,989,200	90,174,200
Net assets (deficiency)	(\$69,235,100)	(\$64,764,900)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$ 219,000	\$115,400
Salvage and other recoveries	23,700	15,800
Total income	242,700	131,200
Expenses	2010	2011
Loss and claims expenses	182,300	(4,501,200)
Administrative expenses	129,200	162,000
Total expenses	311,500	(4,339,200)
Net income (loss)	(\$68,800)	\$4,470,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$7,889,700
Recoveries, net of expenses	9,348,100
Distributions	<u>(10,154,800)</u>
Monetary assets available for distribution	<u>\$7,083,000</u>

Majestic Insurance Company

Conservation Order: April 21, 2011

2011 Report

On April 21, 2011, an Order appointing Conservator and Restraining Orders (“Conservation Order”) was entered by the Superior Court of the State of California with respect to Majestic Insurance Company, a California Corporation. The California Department of Insurance (CDI) conducted an examination of Majestic for the period January 1, 2005 through December 31, 2010. CDI found Majestic’s recorded loss and loss adjustment expense reserves to be deficient by approximately \$40.9 million. Also, due to the increase in reserves, a premium deficiency reserve was required in the amount of \$5.5 million. After these examination adjustments, Majestic’s Risk-Based Capital (RBC) fell within the Mandatory Control Level RBC. The CDI Examination determined that Majestic was operating in a hazardous financial condition in accordance with California Insurance Code Section (CICS) 1011(d). These findings were incorporated into the Commissioner’s application for the Conservation Order.

The Commissioner was appointed as Conservator and directed to conduct the business of Majestic. The Conservator is authorized, in his discretion, to operate the business of Majestic, or so much of the business as he deems appropriate, and to pay or defer payment of some or all proper claims, expenses, liabilities and obligations of Majestic, in whole or in part, accruing prior or subsequent to his appointment. The Conservator continued to operate Majestic’s business in substantially the manner the company was operating prior to conservation, solely for the purpose of preserving Majestic’s business assets and going-concern value in order to facilitate a Plan of Rehabilitation for Majestic (the “Plan”).

Immediately after the entry of the Conservation Order, the Conservator filed a motion seeking court approval of the Plan. Court approval of the Plan was granted on June 2, 2011 and the transactions contemplated by the Plan closed on July 1, 2011. The Plan provided for the assumption of 100% of Majestic’s workers’ compensation claim liabilities by an A-rated insurance company affiliate of AmTrust North America, Inc. (“AmTrust”) via a Loss Portfolio Transfer and Quota Share Reinsurance Agreement (the “Reinsurance Agreement”). Under the Reinsurance Agreement, AmTrust (through an insurance company affiliate, Technology Insurance Company) has assumed the majority of Majestic’s assets and liabilities relating to its workers’ compensation business. Majestic’s in-force policies and expired policies with reported claims have been novated to Technology Insurance Company. The Reinsurance Agreement also provides that all reinsurance contracts providing coverage for the business written by Majestic shall inure to the benefit of AmTrust.

Pursuant to the Conservation Order, continued prosecution of the lawsuits and the filing of any other claims, lawsuits or actions against the Company outside of the conservation proceedings pending in the Superior Court of the State of California, County of San Francisco (the “Conservation Court”), is enjoined. Alternative remedies for the assertion of any and all such claims are provided for under the Conservator’s Rehabilitation Plan. The Rehabilitation Plan provides that the Conservator may request

the Conservation Court to establish a claims bar date for filing proofs of claim against Majestic by non-policyholder creditors. The Rehabilitation Plan further provides that the Conservator shall administer, investigate, adjust and determine all such proofs of claim in a manner consistent with California Insurance Code Sections 1010 through 1062. In accordance with these provisions of the Rehabilitation Plan, the Conservation Court has established a claims bar date of January 31, 2012 for filing non-policyholder proofs of claim with the Conservator. Prior to the claims bar date, the Conservator received a total of 86 proofs of claim which set forth claims of non-policyholder creditors in the aggregate amount of \$205 million. The Conservator is reviewing all such proofs of claim for the purpose of determining such claims as provided in the Rehabilitation Plan.

Majestic Insurance Company

ASSETS AND LIABILITIES¹²

As of December 31, 2011

Assets	12/31/2011
Cash and investments	\$14,895,600
Other assets	1,877,700
Total assets	<u>16,773,300</u>
Liabilities	12/31/2011
Secured claims and accrued expenses	2,372,300
All other claims	629,500
Total liabilities	<u>3,001,800</u>
Net assets (deficiency)	<u><u>\$13,771,500</u></u>

INCOME AND EXPENSES

For Year Ended December 31, 2011

Income	2011
Investment income	\$8,181,000
Other Income	1,029,400
Total income	<u>9,210,400</u>
Expenses	2011
Loss and claims expenses	50,456,100
Net loss from premium write-offs	2,525,208
Total expenses	<u>52,981,308</u>
Net income (loss)	<u><u>(\$43,770,908)</u></u>

¹² Assets and liabilities of Majestic Insurance Company and its operating income and expenses have been audited using statutory basis of accounting as of 12/31/2011

Mission Insurance Company

Conservation Order: October 31, 1985
Liquidation Order: February 24, 1987

Mission National Insurance Company

Conservation Order: November 26, 1985
Liquidation Order: February 24, 1987

Enterprise Insurance Company

Conservation Order: November 26, 1985
Liquidation Order: February 24, 1987

2011 Report

The Mission Insurance Companies' insolvency proceedings began with a court-ordered conservation of the Enterprise entity in November of 1985 with the balance of the entities being conserved on October 31, 1985. All were placed into conservation due to their hazardous financial condition. Efforts to rehabilitate the companies did not succeed, and on February 24, 1987, the companies were ordered into liquidation. Ancillary proceedings in California for HAIC and MRC were initiated concurrent with the Missouri Insurance Director's obtaining a receivership order as the domiciliary liquidator.

In accordance with a court approved closing plan, the Mission estates completed a final policyholder distribution in 2006 whereby all policyholder claimants for Mission, Mission National and Enterprise were paid 100% of their approved claim. As of year-end 2010, the general creditors of the Mission and Enterprise estates have unsatisfied portions remaining on their approved claims.

The Mission estates participate as members of a consolidated tax group (Covanta being the parent) and, as such, are joint and severally liable for the tax exposure of the group. With guidance and advice from tax counsel, the estates have established proper tax reserves for certain open tax years. Once those tax years are closed, the estates will seek court approval to distribute the reserves to claimants or pay the Internal Revenue Service. During 2011 Covanta commenced an audit with the IRS of the consolidated group returns for a number of tax years. The Estate's expect to hear the final conclusion to the audit sometime in 2012.

The Mission estates have commenced making disclosures to the federal authorities to identify and resolve any potential exposure that could be argued as a super priority claim against the estate or the liquidator. Proper notification and disclosure will take place early in 2012 with the objective to gain certainty to the potential exposure and to allow the estates to plan final distributions thereafter. Until that time distributions will be suspended.

Mission Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$102,473,300	\$103,987,600
Recoverable from reinsurers	21,586,400	21,586,400
Other assets	24,027,200	23,979,500
Total assets	148,086,900	149,553,500
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	79,370,900	79,348,700
Claims against policies, before distributions	846,832,600	846,832,600
Less distributions to policyholders	(846,832,600)	(846,832,600)
All other claims	198,438,500	198,438,500
Total liabilities	277,809,400	277,787,200
Net assets (deficiency)	(\$129,722,500)	(\$128,233,700)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$4,254,300	\$1,659,000
Salvage and other recoveries	5,809,600	345,000
Total income	10,063,900	2,004,000
Expenses	2010	2011
Loss and claims expenses	(1,202,800)	47,700
Administrative expenses	700,100	468,400
Total expenses	(502,700)	516,100
Net income (loss)	\$10,566,600	\$1,487,900

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$133,667,000
Recoveries, net of expenses	1,082,928,600
Distributions	<u>(1,112,608,000)</u>
Monetary assets available for distribution	<u>\$103,987,600</u>

Mission National Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$ 22,458,100	\$23,016,800
Recoverable from reinsurers	5,119,900	5,119,900
Other assets	90,600	89,300
Total assets	27,668,600	28,226,000
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	17,753,800	17,756,900
Claims against policies, before distributions	596,098,500	596,098,500
Less distributions to policyholders	(499,851,900)	(499,851,900)
All other claims	16,838,100	16,838,100
Total liabilities	130,838,500	130,841,600
Net assets (deficiency)	(\$103,169,900)	(\$102,615,600)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$679,200	\$366,300
Salvage and other recoveries		
Total income	679,200	366,300
Expenses	2010	2011
Loss and claims expenses		(258,800)
Administrative expenses	103,700	70,700
Total expenses	103,700	(188,100)
Net income (loss)	\$575,500	\$554,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$18,289,000
Recoveries, net of expenses	531,657,000
Distributions	(526,929,200)
Monetary assets available for distribution	<u>\$23,016,800</u>

Enterprise Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$7,015,600	\$7,245,600
Total assets	7,015,600	7,245,600
Liabilities		
Secured claims and accrued expenses	1,240,500	1,240,500
Claims against policies, before distributions	120,573,400	120,573,400
Less distributions to policyholders	(120,573,400)	(120,573,400)
All other claims	30,780,900	30,780,900
Total liabilities	32,021,400	32,021,400
Net assets (deficiency)	(\$25,005,800)	(\$24,775,800)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$22,300	\$114,400
Salvage and other recoveries		148,400
Total income	22,300	262,800
Expenses		
Loss and claims expenses	(5,427,800)	
Administrative expenses	29,100	32,700
Total expenses	(5,398,700)	32,700
Net income (loss)	\$5,421,000	\$230,100

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$3,281,000
Recoveries, net of expenses	129,917,100
Distributions	(125,952,500)
Monetary assets available for distribution	<u>\$7,245,600</u>

Municipal Mutual Insurance Company

Supervision Agreement Date: August 18, 2003
Liquidation Order: October 31, 2006

2011 Report

Municipal Mutual Insurance Company, an excess liability and workers' compensation insurance company doing business only in California, was placed in informal administrative supervision in August of 2003 by the California Department of Insurance. The company had ceased writing business in April of 2003 and was liquidated on October 31, 2006. All insurance claims were transferred to the California Insurance Guarantee Association ("CIGA") for administration and payment.

The Commissioner obtained an order to limit the Proof of Claim process to only the liability policies issued by Municipal Mutual and to that of CIGA. This order will allow CIGA to accept policyholder claims relating to latent exposures into the future.

Of the remaining reinsurance treaties all but one was commuted in 2011. That one treaty attached at a level that had yet to be penetrated. Since there were no current sums owing, the treaty was assigned to CIGA in order for the estate to close.

Pleadings were filed with the court in late December, 2011. The pleadings sought to distribute all remaining assets to CIGA, to confirm the reinsurance assignment to CIGA, and to close the estate. A hearing is scheduled for January 2012 at which time our motions will be heard.

Municipal Mutual Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$1,573,300	\$4,894,800
Recoverable from reinsurers	5,522,700	227,100
Total assets	7,096,000	5,121,900
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	24,400	2,600
Claims against policies, before distributions	11,077,800	11,675,300
Total liabilities	11,102,200	11,677,900
Net assets (deficiency)	(\$4,006,200)	(\$6,556,000)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$49,400	\$43,800
Salvage and other recoveries	62,000	2,800
Total income	111,400	46,600
Expenses	2010	2011
Loss and claims expenses	(93,600)	2,516,500
Administrative expenses	68,300	80,000
Total expenses	(25,300)	2,596,500
Net income (loss)	\$136,700	\$2,549,900

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$920,200
Recoveries, net of expenses	<u>3,974,600</u>
Monetary assets available for distribution	<u>\$4,894,800</u>

Pacific National Insurance Company

Conservation Order: May 14, 2003
Liquidation Order: August 5, 2003

2011 Report

Pacific National Insurance Company (“PNIC”) is a subsidiary of the Highlands Insurance Group. PNIC’s principal business lines include workers’ compensation, commercial multiple-peril, general liability, and commercial automobile insurance. PNIC wrote business exclusively in California.

In October 2002, Highlands Insurance Group and five of its non-insurance subsidiaries commenced Chapter 11 bankruptcy proceedings in the U.S. Bankruptcy Court in the District of Delaware.

On May 14, 2003, the Commissioner was appointed as Conservator of PNIC and on August 5, 2003, the Superior Court appointed the Commissioner as Liquidator of PNIC. Upon liquidation, covered claims were transferred to the appropriate insurance guaranty associations. PNIC’s assets consist primarily of cash and reinsurance receivables. The “Claims Bar Date,” the final date to submit a claim against the Estate, was July 30, 2004.

Highlands Insurance Company (“HIC”) in New Jersey, a subsidiary of Highlands Insurance Group, continues to handle routine administrative services for PNIC under an inter-company agreement. HIC was placed in conservation by the Texas Department of Insurance in November 2003. The CLO continues to work with the Texas Department of Insurance on data transfer/storage and reinsurance collections.

The Estate was successful in commuting a significant reinsurance treaty completing the transaction and recovery in time to prepare for and release a \$19 million early access distribution to the California Insurance Guarantee Association in October 2011. The Estate team will work to collect the remaining reinsurance recoveries in 2012 and position the estate for closure thereafter.

Pacific National Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$8,745,000	\$3,995,900
Recoverable from reinsurers	21,621,300	2,918,800
Total assets	30,366,300	6,914,700
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	8,222,900	838,200
Claims against policies, before distributions	118,855,800	115,755,600
Less distributions to policyholders	(33,416,400)	(52,416,400)
All other claims	246,400	246,400
Total liabilities	93,908,700	64,423,800
Net assets (deficiency)	(\$63,542,400)	(\$57,509,100)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$456,200	\$195,300
Salvage and other recoveries	47,000	765,500
Total income	503,200	960,800
Expenses	2010	2011
Loss and claims expenses	(2,553,700)	(5,278,900)
Administrative expenses	229,200	206,400
Total expenses	(2,324,500)	(5,072,500)
Net income (loss)	\$2,827,700	\$6,033,300

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$36,519,100
Recoveries, net of expenses	19,893,200
Distributions	<u>(52,416,400)</u>
Monetary assets available for distribution	<u>\$3,995,900</u>

**Superior National Insurance Companies in Liquidation (“SNICIL”)
(California Compensation Insurance Company, Combined Benefits Insurance Company, Commercial Compensation Casualty Company, Superior National Insurance Company, and Superior Pacific Casualty Company)**

Conservation Order: March 6, 2000
Liquidation Order: September 26, 2000

2011 Report

On March 6, 2000, the Los Angeles County Superior Court (the “Court”) ordered and appointed the Insurance Commissioner to serve as Conservator of four workers’ compensation insurance companies: Superior National Insurance Company, Superior Pacific Casualty Company, California Compensation Insurance Company and Combined Benefits Insurance Company. On June 9, 2000, the Court ordered and appointed the Commissioner to serve as conservator of a fifth workers’ compensation insurance company named Commercial Compensation Casualty Company. In his capacity as Conservator, the Insurance Commissioner obtained title to and possession of all the property and assets of the five estates, collectively identified as Superior National Insurance Companies in Liquidation (“Superior National Estates”).

In September 26, 2000, the Court found that each of the Superior National Estates was insolvent and that it would be futile to proceed as Conservator; on that basis, the Court terminated the Insurance Commissioner’s status as Conservator of the five insurers and ordered and appointed the Commissioner to serve as Liquidator of the insurers.

The charge in liquidating the Superior National Estates was to marshal assets, pay claims and resolve the vast business affairs as efficiently as possible. In this regard, the Liquidator consolidated the Superior National Estates’ operations into the Conservation and Liquidation Office (San Francisco) in September 2003.

In 2011 the Superior National Estates distributed \$114,477,048 to Guaranty Associations and approved policyholder class claims (Class 2) not covered by Guaranty Associations in partial satisfaction of all Class 2 Proof of Claims. The percentage paid by each estate varied based on assets available and liabilities charged to each estate:

- California Compensation paid to a level of 50% for Guaranty Associations and 43% for non-IGA covered policyholder class claims.
- Combined Benefits paid to a level of 88% non-IGA covered policyholder class claims.
- Superior National paid to a level of 48% for Guaranty Associations and 41% for non-IGA covered policyholder class claims.
- Superior Pacific paid to a level of 16% for non-IGA covered policyholder class claims.
- Commercial Compensation paid to a level of 80% for Guaranty Associations and 73% for non-IGA covered policyholder class claims.

Distributions made to the Guaranty Association were paid at a higher percentage since they were required, and had agreed in writing, to return money previously distributed as may be required to pay claims of secured creditors and claims falling within the priorities of subdivision (a) of Section 1033. Since the non-IGA covered claimants are not obligated to return any distribution made, and ensure that there is no excess distribution, the percentage distributed was 7% less.

Under the most optimistic estimates, SNICIL has insufficient assets to fully pay the policyholder claims. Consequently, once all asset recoveries are fully monetized, the Estate will seek court approval not to review any claims below the policyholder class.

There is one potential frictional issue remaining concerning an Indemnity agreement running in favor of the parent company (in bankruptcy receivership) which will have to be addressed.

The largest remaining asset on the books of the Estates are reinsurance recoverables of approximately \$165,000,000 (includes IBNR). The Estates' continuing and ultimate goal is to fully resolve its reinsurance recoverables through treaty commutations, since Workers' Compensation claims are such long-tailed claims that conceivably there could be reinsurance billing for the next 50 years. Once reinsurance has been resolved and the balance of the Oregon deposit returned to the Superior National Insurance Company estate, the Liquidator can seek closure.

California Compensation Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$ 194,243,900	\$75,751,500
Recoverable from reinsurers	165,825,700	73,872,700
Other assets	2,700	2,200
Total assets	360,072,300	149,626,400
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	21,810,700	21,964,800
Claims against policies, before distributions	2,005,314,100	2,045,294,500
Less distributions to policyholders	(646,484,100)	(840,907,800)
All other claims	119,321,000	119,308,000
Total liabilities	1,499,961,700	1,345,659,500
Net assets (deficiency)	(\$1,139,889,400)	(\$1,196,033,100)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$3,945,900	\$2,001,800
Litigation recoveries	111,463,700	
Salvage and other recoveries	3,734,900	3,948,300
Total income	119,144,500	5,950,100
Expenses	2010	2011
Loss and claims expenses	81,262,500	60,771,200
Administrative expenses	1,571,100	1,322,800
Total expenses	82,833,600	62,094,000
Net income (loss)	\$36,310,900	(\$56,143,900)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$165,879,200
Recoveries, net of expenses.....	750,780,100
Distributions	(840,907,800)
Monetary assets available for distribution	<u>\$75,751,500</u>

Combined Benefits Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$8,190,800	\$13,297,400
Recoverable from reinsurers	6,437,100	216,400
Total assets	14,627,900	13,513,800
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	203,700	204,200
Claims against policies, before distributions	34,172,600	34,211,800
Less distributions to policyholders	(21,480,400)	(21,482,200)
All other claims	6,895,300	6,713,200
Total liabilities	19,791,200	19,647,000
Net assets (deficiency)	(\$5,163,300)	(\$6,133,200)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$126,300	\$211,000
Litigation recoveries	3,119,700	
Salvage and other recoveries	188,700	276,800
Total income	3,434,700	487,800
Expenses	2010	2011
Loss and claims expenses	2,937,700	1,384,000
Administrative expenses	69,600	73,900
Total expenses	3,007,300	1,457,900
Net income (loss)	(\$427,400)	\$970,100

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$11,115,400
Recoveries, net of expenses	23,664,200
Distributions	(21,482,200)
Monetary assets available for distribution	<u>\$13,297,400</u>

Superior National Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$34,561,000	\$ 32,851,400
Recoverable from reinsurers	99,122,600	47,099,100
Other assets	20,000	19,800
Total assets	133,703,600	79,970,300
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	4,979,000	5,045,000
Claims against policies, before distributions	860,151,000	884,667,000
Less distributions to policyholders	(341,703,100)	(391,018,100)
All other claims	28,775,900	28,745,900
Total liabilities	552,202,800	527,439,800
Net assets (deficiency)	(\$418,499,200)	(\$447,469,500)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$ 1,832,500	\$ 1,332,200
Litigation recoveries	57,992,000	
Salvage and other recoveries	3,356,900	3,495,100
Total income	63,181,400	4,827,300
Expenses	2010	2011
Loss and claims expenses	2,267,800	33,363,100
Administrative expenses	586,900	434,600
Total expenses	2,854,700	33,797,700
Net income (loss)	\$60,326,700	(\$28,970,400)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$68,622,300
Recoveries, net of expenses	355,247,200
Distributions	(391,018,100)
Monetary assets available for distribution	<u>\$32,851,400</u>

Superior Pacific Casualty Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$2,328,700	\$3,608,400
Recoverable from reinsurers	34,416,100	37,177,600
Total assets	36,744,800	40,786,000
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	72,400	72,800
Claims against policies, before distributions	223,386,200	224,074,200
Less distributions to policyholders	(38,094,300)	(38,096,100)
All other claims	62,526,000	62,503,300
Total liabilities	247,890,300	248,554,200
Net assets (deficiency)	(\$211,145,500)	(\$207,768,200)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$ 280,200	\$48,600
Litigation recoveries	22,400	
Salvage and other recoveries	708,400	110,600
Total income	1,011,000	159,200
Expenses	2010	2011
Loss and claims expenses	16,150,200	(3,519,500)
Administrative expenses	306,000	301,600
Total expenses	16,456,200	(3,217,900)
Net income (loss)	(\$15,445,200)	\$3,377,100

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$58,666,300
Recoveries, net of expenses	(16,961,800)
Distributions	<u>(38,096,100)</u>
Monetary assets available for distribution	<u>\$3,608,400</u>

Commercial Compensation Casualty Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$7,216,100	\$13,443,000
Recoverable from reinsurers	27,595,300	7,477,300
Other assets	900	500
Total assets	34,812,300	20,920,800
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	1,580,300	1,770,200
Claims against policies, before distributions	137,520,100	137,882,600
Less distributions to policyholders	(83,849,900)	(93,984,300)
All other claims	13,741,900	13,754,500
Total liabilities	68,992,400	59,423,000
Net assets (deficiency)	(\$34,180,100)	(\$38,502,200)

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$564,400	\$357,200
Litigation recoveries	13,277,700	
Salvage and other recoveries	421,400	608,200
Total income	14,263,500	965,400
Expenses	2010	2011
Loss and claims expenses	(1,008,100)	5,228,400
Administrative expenses	105,000	59,100
Total expenses	(903,100)	5,287,500
Net income (loss)	\$15,166,600	(\$4,322,100)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$6,420,700
Recoveries, net of expenses	101,006,600
Distributions	(93,984,300)
Monetary assets available for distribution	<u>\$13,443,000</u>

Western Employers Insurance Company

Conservation Order: April 2, 1991
Liquidation Order: April 19, 1991

2011 Report

Western Employers Insurance Company (“WEIC”) began as a New York-domiciled insurer known as Leatherby Insurance Company and was re-domesticated to California in the late 1970s. The company was licensed in all 50 states including D.C. and wrote primarily workers’ compensation and commercial multi-peril insurance. After four years of attempted self-liquidation, WEIC determined it could no longer continue to liquidate without the assistance of the California Department of Insurance. An order placing WEIC into liquidation was entered on April 19, 1991.

WEIC’s primary objective will be to resolve all asset recoveries, principally reinsurance assets at this juncture, determine final estate liability and position the Estate for closure by 2016. A significant requirement to meet that objective is to determine how to quantify the remaining long-tail exposure.

On February 2, 2010, the San Francisco Superior Court set a deadline of August 31, 2010 by which all holders of claims, other than workers’ compensation claims, must submit detailed claim updates which set forth the facts regarding the further developments of those claims.

Currently, all claims that were submitted with the update continue to be reviewed. Two distinct problems slow the claims determination process. First is the fact that claims must be liquidated before they can be approved, and WEIC wrote a significant number of excess and umbrella policies for environmental type exposures, and the losses continue to accumulate but have not reached an attachment point yet. Secondly, we are attempting to complete the Federal Claim Waiver process to insulate the Estate from any potential of latent liability assessed by the Federal Government.

Western Employers Insurance Company

ASSETS AND LIABILITIES

As of December 31, 2010 and December 31, 2011

Assets	12/31/2010	12/31/2011
Cash and investments	\$125,967,700	\$127,666,100
Recoverable from reinsurers	15,700,600	16,269,800
Total assets	141,668,300	143,935,900
Liabilities	12/31/2010	12/31/2011
Secured claims and accrued expenses	1,500	1,000
Claims against policies, before distributions	210,565,000	180,490,700
Less distributions to policyholders	(67,070,000)	(68,190,000)
All other claims	6,352,500	6,377,300
Total liabilities	149,849,000	118,679,000
Net assets (deficiency)	(\$8,180,700)	\$25,256,900

INCOME AND EXPENSES

For Year Ended December 31, 2010 and 2011

Income	2010	2011
Investment income	\$3,688,600	\$2,101,400
Salvage and other recoveries	83,500	20,000
Total income	3,772,100	2,121,400
Expenses	2010	2011
Loss and claims expenses	27,680,900	(31,957,000)
Administrative expenses	657,700	641,000
Total expenses	28,338,600	(31,316,000)
Net income (loss)	(\$24,566,500)	\$33,437,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	\$74,867,900
Recoveries, net of expenses	120,988,200
Distributions	(68,190,000)
Monetary assets available for distribution	<u>\$127,666,100</u>

Section 3 – Cross Reference to California Insurance Code (CIC)

CIC Section 1060 - The Commissioner shall transmit all of the following to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance in the annual report submitted pursuant to Section 12922:

	Page
(a) The names of the persons proceeded against under this article.....	206
(b) Whether such persons have resumed business or have been liquidated or have been mutualized.....	206
(c) Such other facts on the operations of the Conservation & Liquidation Office as will acquaint the Governor, the policyholders, creditors, shareholders and the public with his or her proceedings under this article, including, but not limited to:	
(1) An itemization of the number of staff, total salaries of staff, a description of the compensation methodology, and an organizational flowchart.	189, 196, 197
(2) Annual operating goals and results.	190, 192
(3) A summary of all Conservation and Liquidation Office costs, including an itemization of internal and external costs, and a description of the methodology used to allocate those costs among insurer estates.	193, 198
(4) A list of all current insolvencies not closed within ten years of a court ordered liquidation, and a narrative explaining why each insolvency remains open.	199-201
(5) An accounting of total claims by estate.	202
(6) A list of current year and cumulative distributions by class of creditor for each estate.....	205
(7) For each proceeding, the net value of the estate at the time of conservation or liquidation and the net value at the end of the preceding calendar year....	207-249
(d) Other facts on the operations of the individual estates as will acquaint the Governor, Legislature, policyholders, creditors, shareholders, and the public with his or her proceedings under this article, including, but not limited to:	
(1) The annual operating goals and results.....	207-249
(2) The status of the conservation and liquidation process.	207-249
(3) Financial statements, including current and cumulative distributions, comparing current calendar year to prior year.	207-249