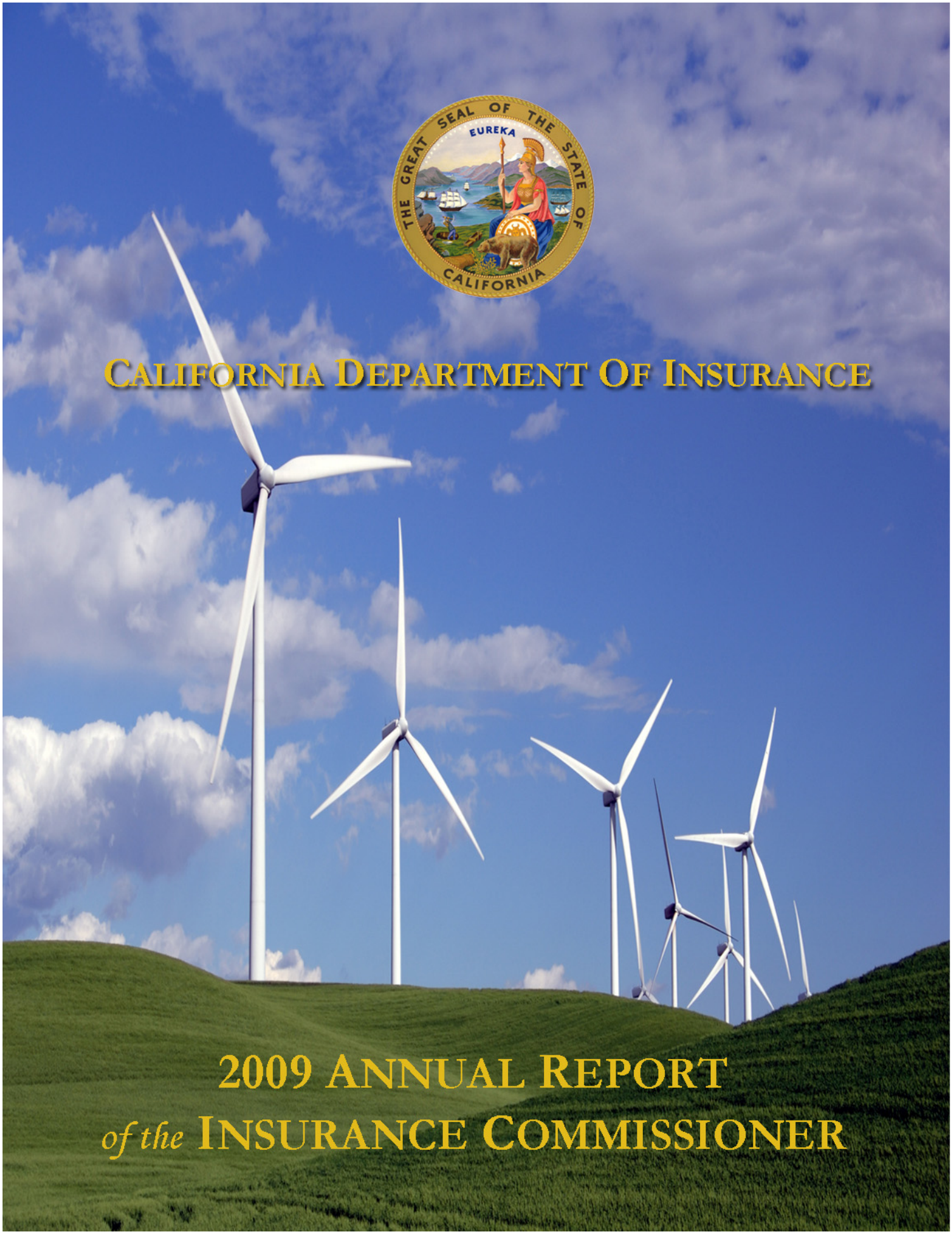

California Department Of Insurance

2009 Annual Report *of the* Insurance Commissioner

STATE OF CALIFORNIA Steve Poizner, *Insurance Commissioner*

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July 30, 2010

The Honorable Arnold Schwarzenegger
Governor of California
State Capitol Building
Sacramento, CA 95814

Dear Governor Schwarzenegger:

I am pleased to provide you the *2009 Annual Report of the Insurance Commissioner* as required by California Insurance Code ("CIC") section 12922.

To benefit California's insurance consumers, I have collected and analyzed as much information as possible. Accordingly, this *Annual Report* includes the information mandated by the following CIC statutes:

- §1060 – insurer insolvency and delinquency proceedings;
- §1707.7 – agent and broker licensing statistics;
- §1872.83(h) – workers' compensation fraud-fighting efforts and results;
- §1872.85(d) – activities of the Fraud Division investigating and prosecuting fraudulent disability insurance claims;
- §1872.9 – activities undertaken to reduce fraud under the Insurance Frauds Prevention Act;
- §1874.8(f) – results of the Organized Automobile Fraud Activity Interdiction Program;
- §10089.83(a) – program statistics about the Department's mediation of claims disputes;
- §12921.1(a)(10) – information about the Department's investigations of consumer complaints about claims handling by insurers;
- §12921.4(b) – evaluation of complaint patterns and actions taken with respect to those complaints;
- §12962 – analysis of programs to: ensure the availability of liability insurance, and prevent arbitrary rates and practices.

Finally, the report presents synopses of various reports filed with the Department, an overview of the Department's activities by branch and a summary of California's insurance industry and interests.

Sincerely,

STEVE POIZNER
Insurance Commissioner

CC: Diane F. Boyer-Vine, Legislative Counsel
Gregory Schmidt, Secretary of the Senate

California Department of Insurance
2009 Organizational Chart (Graphical Version)

INSURANCE COMMISSIONER

CHIEF OF STAFF

OFFICE OF STRATEGIC PLANNING

CONSERVATION & LIQUIDATION 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

ADMINISTRATIVE ASSISTANT TO THE COMMISSIONER

LEGAL/CHIEF COUNSEL

Deputy Chief Counsel
Government Law
Corporate Affairs I / II
Rate Enforcement
Policy Approval
Sacramento Enforcement
San Francisco Enforcement
Auto Enforcement
Fraud Liaison
Public Advisor

POLICY & REGULATIONS

Special Projects
Policy Research
Statistical Analysis
External Task Force
Workers' Compensation Initiatives

COMMUNITY RELATIONS

Low Cost Auto
Consumer Education & Outreach
California Organized Investment Network
Office of the Ombudsman

LEGISLATIVE

Legislative Office
Health Insurance Advisor

COMMUNICATIONS & PRESS RELATIONS

California Department of Insurance
2009 Organizational Chart (Accessible Text Version)

INSURANCE COMMISSIONER

- CHIEF OF STAFF
  - OFFICE OF STRATEGIC PLANNING
  - CONSERVATION & LIQUIDATION OFFICE
  - ADMINISTRATIVE ASSISTANT TO THE COMMISSIONER

CHIEF OF STAFF

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
- Government Law
- Corporate Affairs I/II
- Rate Enforcement
- Policy Approval
- Sacramento Enforcement
- San Francisco Enforcement
- Auto Enforcement
- Fraud Liaison
- Public Advisor

POLICY & REGULATIONS

- Special Projects
- Policy Research
- Statistical Analysis
- External Task Force
- Workers' Compensation Initiatives

COMMUNITY RELATIONS

- Low Cost Auto
- Consumer Education & Outreach
- California Organized Investment Network
- Office of Ombudsman

LEGISLATIVE

- Legislative Office
- Health Insurance Advisor

COMMUNICATIONS & PRESS RELATIONS

EXECUTIVE OPERATIONS

- Executive Office
- Information Assurance & Organizational Accountability Office
- Information Security Office
- Office of Civil Rights
- Administrative Hearing Bureau
- Office of Market Competition

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CONSERVATION AND LIQUIDATION OFFICE

Conservation and Liquidation Office

Section 1 – The Conservation & Liquidation Office

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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 capacity, the Commissioner is responsible for taking possession (conservation) of the assets of financially troubled insurance enterprises domiciled in California. An enterprise subject to a conservation or liquidation order is referred to as an estate.

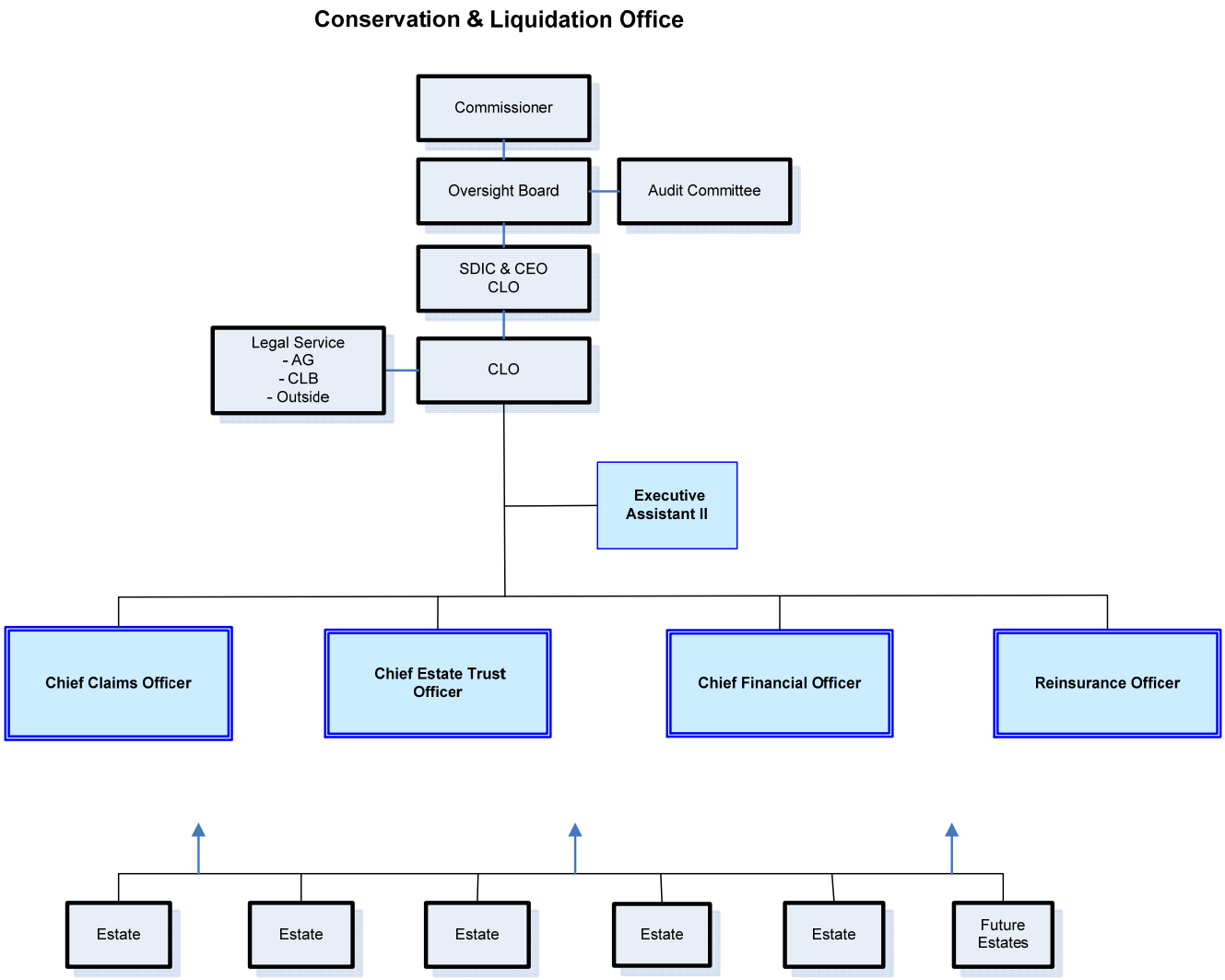
The Commissioner applies to the Superior Court for a conservation order to place a financially troubled enterprise in conservatorship. Under a conservation order, the Commissioner takes possession of the estate's financial records and real and personal property, and conducts the business of the estate 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 discharge the Commissioner's responsibilities as conservator, receiver and liquidator.

The CLO was created in 1994 to be the successor to the Conservation & Liquidation Division of the Department of Insurance, which was managed by State employees. The CLO is based in San Francisco, California.

As of December 31, 2009, the CLO was responsible for the administration of 23 insurance estates.



Text Version of the Conservation & Liquidation Office (CLO) Organization Chart

Conservation and Liquidation Office
- Insurance Commissioner
  - Audit Committee
  - Oversight Board
    - SDIC & CEO-CLO
      - CLO
        - Legal Service (AG, CLB, Outside Law Firm)
        - Executive Assistant II
        - Chief Claims Officer
        - Chief Estate Trust Officer
        - Chief Financial Officer
        - Reinsurance Officer

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. The current Committee members are Jesse Huff, Chief Deputy Commissioner, Adam Cole, Deputy Commissioner and General Counsel, and Sherwood Girion, Deputy Commissioner-Financial Surveillance. The Committee meets on a quarterly basis throughout the year.

During 2009, the Oversight Board and Audit Committee held four regularly scheduled meetings. There was 92% attendance by the Committee members at all meetings (one member missed one meeting as a result of illness).

2009 Organizational Goals and Results

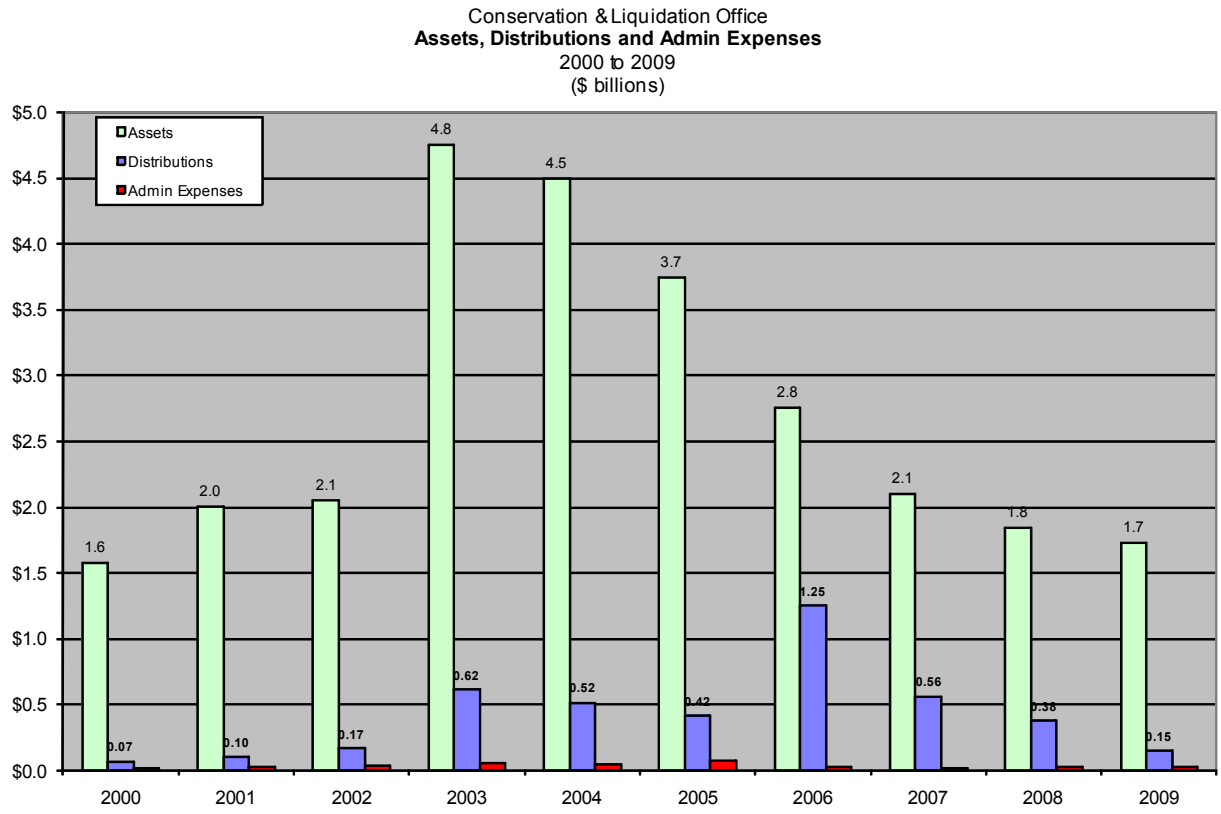
On an annual basis, the CLO prepares a business plan for the organization supporting the CLO Mission Statement. The Business Plan is then presented to the Board for approval. The CLO's Mission Statement is as follows:

> 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 2009 Business Plan was a continuation of the objectives of the 2008 Business Plan, focusing on estate closings and distributions, collecting/converting assets, evaluating claims and enhancing the operating efficiencies of the CLO.

Entering 2009, there were 26 open estates in liquidation under management by the CLO. The open estates consist of 23 Property & Casualty Estates, two Workers' Compensations, and one Life/Health Estate (the Executive Life Insurance Company, which was placed into liquidation in 1991). The CLO goal in 2009 was to close five estates and distribute $100 million.

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



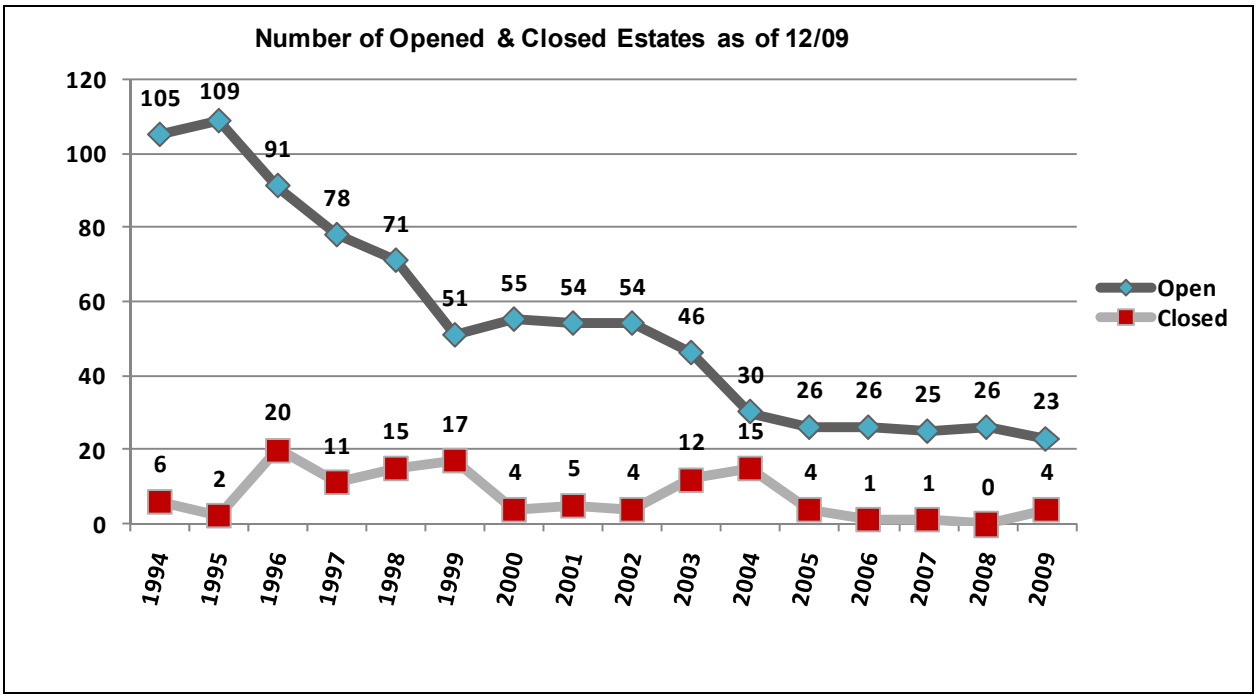
The chart above displays the Conservation & Liquidation Office Assets, Distributions and Administrative Expenses from the year 2000 to 2009.The table below lists these figures which are in billions.

Year	Assets ($ billions)	Distributions ($ billions)	Admin. Expenses ($ billions)
2000	$1.6	$0.07	$0.02
2001	$2.0	$0.10	$0.02
2002	$2.1	$0.17	$0.04
2003	$4.8	$0.62	$0.05
2004	$4.5	$0.52	$0.05
2005	$3.7	$0.42	$0.08
2006	$2.8	$1.25	$0.03
2007	$2.1	$0.56	$0.02
2008	$1.8	$0.38	$0.03
2009	$1.7	$0.15	$0.03

The 2009 goals and results are as follows:

1. Closings

GOAL	RESULTS
Close 5 Estates: 1) Enterprise 2) Paula 3) Western Employers of America 4) Western Growers 5) Western International	Four of the five estates were closed during 2009. One estate targeted for closure, Enterprise, has one final asset receivable to collect from its parent company before it can make a final distribution and position the estate for closure.



The chart above shows the number of Estates which have opened or closed each year from 1994 to 2009: 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.

Since 1994, there have been approximately 121 estates closed. These estates consisted of 55 ancillaries, 22 title companies, and 44 “regular” insurers. Ancillary and title companies typically require limited work on behalf of the liquidator.

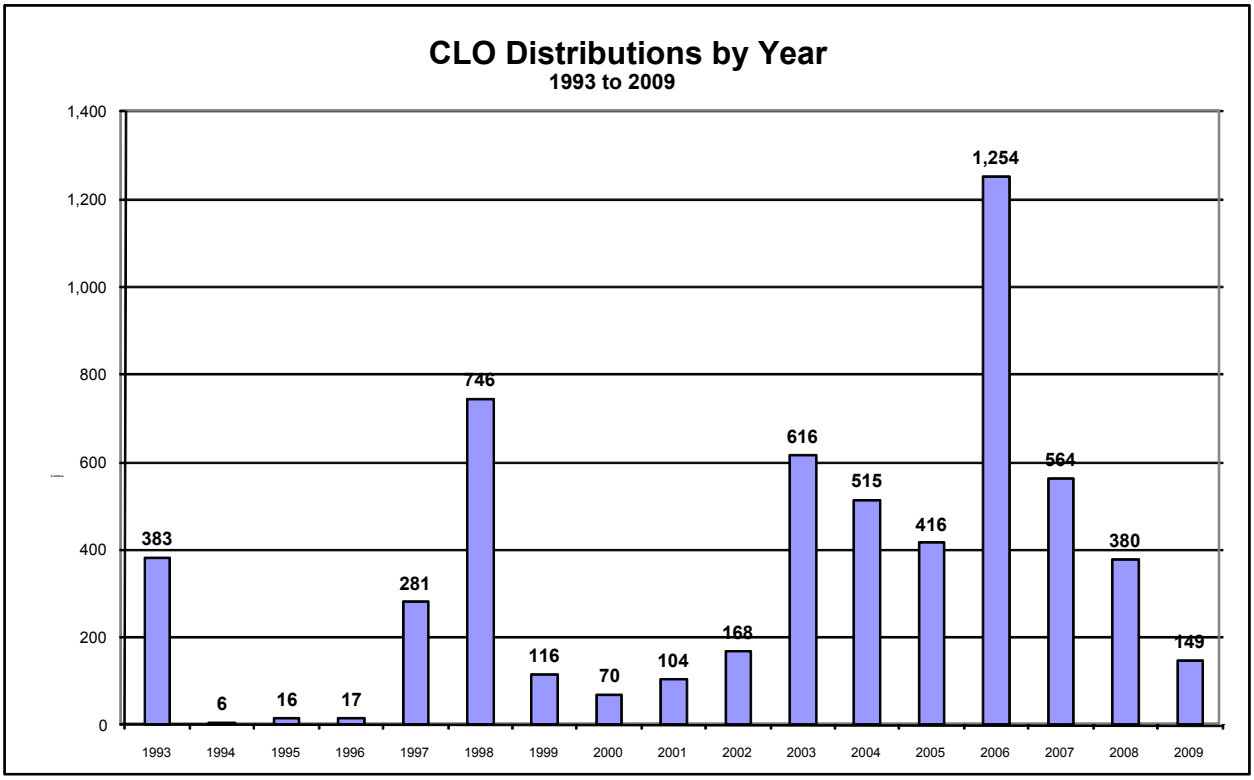
2. Distributions

Early Access Distributions

Distributions	2009 Actual ($Millions)	2009 Goal ($Millions)
Fremont	$ 49.6	$50
Superior National	$56.2	$0
HIH EAD returned	- $1.6	$0
Sub-total:	**$104.2**	**$50**

Final Distributions

Distributions	2009 Actual ($Millions)	2009 Goal ($Millions)
Enterprise	$4.9	$4
National Auto	$26.9	$23
Sable	$0	$13
Western Employers of America	$11.8	$10
Western International	$0.8	$0
Sub-total:	**$44.4**	**$50**
TOTAL DISTRIBUTIONS:	**$148.6**	**$100**



The chart above lists the CLO Distributions for each year from 1993 to 2009. The dollar amounts represented are in the millions:

1993, 383; 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.

CLO Investment Policy

The CLO has a formal investment policy 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 +/- 6 months of the Barclays Capital U.S. Government/Credit 1-3 Yr., which was 19 months at December 31, 2009.

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, 2009, the CLO had $539 million of estate marketable investment securities under management.

For the year ending December 31, 2009, the average portfolio balance was approximately $580 million. The portfolio earned an interest yield of 4.0% and a net yield after security gains/losses and mark-to-market adjustments of 7.2%.

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 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.

[1] See "Combined Financial Results" section of this report on the budget, and actual expenditures for 2009 for direct and indirect expenses.

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.

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.
- Compensation increases are based on performance.

CLO employment and total salaries for employees are summarized below:

	31-Dec-09	31-Dec-10
Number of CLO employees at beginning of year	67.5	53.5
Total compensation for CLO employees	$ 8,263,721	$ 6,789,882

The chart above shows the number of CLO employees from 2004 to 2010:

2004, 103; 2005, 91; 2006, 87; 2007, 76; 2008, 67.5; 2009, 53.5; 2010, 51.5 projected.

As estates have closed resulting in reduced workloads and as a result of internal operating efficiencies, the number of full-time employees decreased by 20.7% in 2009 compared to 2008, and by 48% compared to December 31, 2004.

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.

CLO Financial Results

For Years Ended December 31, 2009 and December 31, 2008

Cash received	December 31, 2009		December 31, 2008
	Actual	Budget	
Litigation and reinsurance recoveries	$86,965,900	N/A[2]	$96,658,600
Investment income, net of expenses	42,943,900	N/A[3]	26,137,800
Total:	**$129,909,800**		**$122,796,400**

[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, 2009		December 31, 2008
	Actual	Budget	
Distributions	**$148,556,800**	**$100,000,000**	**$380,151,900**

Administrative – Estate Direct Expenses

Estate Direct Expenses	December 31, 2009		December 31, 2008
	Actual	Budget	
Legal expenses	$12,831,300	$16,547,900	$8,934,200
Consultants and contractors	2,710,800	2,746,700	2,580,700
Office expenses	3,107,000	2,305,800	2,441,100
Compensation and benefits	863,300	797,300	863,300
Total	$19,512,200	$22,397,700	$14,819,300

Administrative – CLO Overhead Expenses

CLO overhead expenses	December 31, 2009		December 31, 2008
	Actual	Budget	
Compensation and benefits	$7,400,700	$7,342,800	$7,320,400
Office expenses	2,631,100	2,975,600	2,695,300
Consultants and contractors	320,100	596,000	711,800
Legal expenses	45,400	28,000	14,100
Total	$10,397,300	$10,942,400	$10,741,600

Administrative Totals	December 31, 2009		December 31, 2008
	Actual	Budget	
Estate Direct Expense Total	$19,512,200	$22,397,700	$14,819,300
CLO Overhead Expense Total	$10,397,300	$10,942,400	$10,741,600
Total:	**$29,909,500**	**$33,340,100**	**$25,560,900**

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:

Citation General:

The Estate wrote coverage on a broad range of long-tail insurance exposures. The 10-year statute of limitations on most of Citation's risks expired in late 2005, and a distribution of available funds was made to policyholder claims[4] in 2008. The Estate continues to have federal income tax exposure until its final liability to its consolidated parent is resolved. Once such resolution can be made, the Estate will distribute the remaining assets and prepare for closure. At a minimum, all approved POC's will be paid in 2010.

[4] Policyholder claims are Class 2 claims under the current priority of payment scheme defined in the California Insurance Code 1033. Prior to 1998, policyholder claims were Class 5 claims. The date of liquidation governs which statutory priority scheme is applicable

Executive Life & ELIC Opt Out Trust:

Continuing asset recovery, via complex litigation, has required the Estate to remain open. The damages phase of the Insurance Commissioner's lawsuit against Altus has not been scheduled at this time. The Estate and associated trusts 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.

Golden Eagle:

The Estate is in long-term run off. Although all policyholder claims have been reinsured, Golden Eagle remains liable to the policyholders should the reinsurer not be able to fulfill their obligations under the contract. 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. The claimants have received 100% reimbursement for 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 from other insolvency proceedings. The estates are subject to a potentially significant federal income tax liability as a participant in a consolidated tax group. As tax years close, the tax reserves will be released and distributed to remaining creditors. All three estates will be required to complete the escheatment process once all funds have been distributed.

Western Employers:

Western Employers wrote coverage on very long-tail exposures (asbestos, tobacco, etc.) and has been subject to extensive litigation associated with claims that exceed state guaranty fund limits or were altogether not covered. 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 assets.

Property and Casualty Estates

Claims History

Estate	Liquidation Date	Claims Filed	Claims Adjudicated	Open Claims	# of Guaranty Associations
Alistar	10/24/2002	355	355	0	1
Citation	8/24/1995	1,107	1,107	0	1
Frontier Pacific	11/30/2001	33,631	33,628	3	2
Fremont	7/2/2003	45,095	44,287	808	49
Fremont Life	Not liquidated				
Golden Eagle[5]	2/18/1998	n/a (see below)			
Golden State Mutual	Not liquidated				
HIH (2 estates)	5/8/2001	3,169	3,169	0	26
Municipal Mutual	10/31/2006	4	3	1	1
Mission (3 estates)	2/24/1987	173,920	173,920	0	0
National Auto	4/23/2002	3,099	3,099	0	4
Pacific National	8/5/2003	4,447	4,447	0	1
Paula	n/a (estate closed)				
Superior (5 estates)	9/26/2000	13,890	13,888	2	62
Sable	7/17/2001	377	377	0	4
Western Employers	4/19/1991	9,228	8,919	604	48
Western Employers Amer.			n/a (estate closed)		
Western Growers			n/a (estate closed)		
Western Int'l.			n/a (estate closed)		
	Total:	**288,322**	**287,199**	**1,418**	**199**

[5] *Golden Eagle is subject to a finding of statutory insolvency. All claims are covered under a reinsurance agreement and are being paid by the reinsurer.*

NOTE: Open estates have claims made by state insurance guaranty associations, which will not be determined until the estate is in process of closing. Numbers above reflect numbers of Guaranty Association claims still awaiting determination.

Paula, Western Growers, Western Employers of America, and Western International estates closed in 2009 and will no longer be reported.

Life Insurance Estate

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

2010 Business Goals

The 2010 Business Plan is a continuation of the objectives of the 2009 Business Plan, focusing on estate closings and distributions, collecting/converting assets, evaluating claims and enhancing the operating efficiencies.

Entering 2010, there are 23 open estates in liquidation under management by the CLO. The open estates consist of 19 Property & Casualty Estates, one Workers' Compensation and three Life/Health Estates. Our goal in 2010 is to close two estates and distribute $161 million.

Starting 2010, we have 53.5 full-time employees and no temporary employees. We will continue a planned reduction in staff during 2010. Staffing may need to be added to some areas to meet specific work needs and, when necessary, to strengthen the internal control environment and infrastructure of the CLO.
In addition to the organizational goals, there are individual work plans and cross-departmental Estate teams for each of the 23 estates.

The 2010 Goals are as follows:

1. Close 2 Estates[6]
   - National Auto
   - Municipal Mutual
2. Early Access, Interim, and Final Distributions

Early Access Distributions:	
Fremont	$50,000,000
Pacific National	12,000,000
Superior National Estates	15,000,000
Interim Distributions:	
Citation General	5,000,000
Mission	60,000,000
Sable	15,000,000
Final Distributions:	
Enterprise	TBD
Municipal Mutual	4,000,000
	$161,000,000

[6] *Closing is defined as fully releasing the Commissioner from all legal responsibilities for an estate.*

Section 2 – Estate Specific Information

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Conservation or Liquidation Estates Opened During the Year 2009

Golden State Mutual Life Ins. Co. was conserved on September 30, 2009.

Conservation or Liquidation Estates Closed During the Year 2009

Paula Ins. Co. – 10/22/09

Western Growers Ins. Co. – 02/11/09

Western International Ins. Co. – 12/01/09

Western Employers Ins. Co. of America – 12/29/09

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

	Year Ended 12/31/2009				Cumulative to 12/31/2009			
Estate Name	Policy-holders	Federal and State Claims Having Preference	General Creditors	Total	Policy-holders	Federal and State Claims Having Preference	General Creditors	Total
Alistar Ins Company					$8,073	$0	$0	$8,073
Citation General Ins Company					17,133			17,133
Executive Life Ins Company					737,276			737,276*
Fremont Indemnity Ins Company	49,636			49,636	859,789			859,789
Great States Ins Company	3			3	10,155			10,155
HIH America Ins Company	(1,581)			(1,581)	278,088			278,088
Mission Ins Company					846,630	111	207,251	1,053,992
Mission National Ins Company					499,607		27,077	526,684
Enterprise Ins Company			4,928	4,928	120,573	40	5,339	125,952
National Automobile & Casualty Ins Company	23,036	14	3,877	26,928	23,428	14	3,877	27,319
Pacific National Ins Company					23,416			23,416
Paula Ins Company	(4)			(4)	139,004			139,004
Sable Ins Company					6,661			6,661
California Compensation Ins Company	30,883			30,883	472,101			472,101
Combined Benefits Ins Company	993			993	18,209			18,209
Superior National Ins Company	22,921			22,921	187,172			187,172
Superior Pacific Casualty Company	(14)			(14)	30,587			30,587
Commercial Compensation Casualty Company	1,460			1,460	49,443			49,443
Western Employers Ins Company	(116)			(116)	62,914			62,914
Western Employers Ins Company of America	1,141		10,618	11,759	2,781		10,618	13,398
Western Growers Ins Company					18,101			18,101
Western International Ins Company	760			760	28,172			28,172
	$129,119	$14	$19,423	$148,557	$4,439,312	$165	$254,163	$4,693,640

*Since administration was transferred to CLO in 1997.

Estates in Conservation and/or Liquidation as of December 31, 2009

Estate Name	Date Conserved	Date Liquidated
Alistar Insurance Company	04/11/02	10/24/02
California Compensation Insurance Company	03/06/00	09/26/00
Citation General Insurance Company	07/21/95	08/24/95
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	*
Great States Insurance Company	03/30/01	05/08/01
HIH America Comp. & Liability Insurance Company	03/30/01	05/08/01
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
National Automobile Casualty Insurance Company	03/15/02	04/23/02
Pacific National Insurance Company	05/14/03	08/05/03
Sable Insurance Company	05/10/01	07/17/01
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 2009 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 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**

2009 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 identify and run off the reinsurance program.

During 2009, the Estate's goal was to bill active reinsurance treaties and to position the remaining reinsurance agreements for commutation. The Reinsurance Department has obtained updated actuarial studies and are in negotiations with two primary reinsurers to commute their treaties. Absent a settlement with the reinsurers in the near term, the Estate will work with CIGA to assign the remaining reinsurance treaties to them and allow the Estate to make its final distribution.

The Estate's immediate goal is to resolve the final two reinsurance contracts through commutation or assignment. Thereafter all policyholder claims liability will be determined and a final distribution paid. The Estate will seek to make the final distribution by 2011 and close the Estate thereafter subject to any escheatment requirements.

Alistar Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$11,810,300	$14,170,000
Recoverable from reinsurers	4,727,800	9,438,800
Other assets	6,000	1,500
Total assets	16,544,100	23,610,300

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	285,700	283,500
Claims against policies, before distributions	43,810,100	47,911,200
Less distributions to policyholders	(8,073,200)	(8,073,200)
All other claims	111,000	111,000
Total liabilities	36,133,600	40,232,500
Net assets (deficiency)	($19,589,500)	($16,622,200)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$211,500	$858,000
Salvage and other recoveries	215,100	104,100
Total income	426,600	962,100

Expenses	2008	2009
Loss and claims expenses	7,653,500	(2,279,500)
Administrative expenses	229,800	274,300
Total expenses	7,883,300	(2,005,200)
Net income (loss)	($7,456,700)	$2,967,300

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$13,361,500
Recoveries, net of expenses	8,881,700
Distributions	(8,073,200)
Monetary assets available for distribution	$14,170,000

Citation General Insurance Company

Conservation Order: **July 21, 1995**
Liquidation Order: **August 24, 1995**

2009 Report

Citation General Insurance Company ("Citation") was the successor to Canadian Insurance Company and Canadian Insurance Company of California via an Assumption Agreement dated February 13, 1986. Citation wrote primarily Medical Malpractice, Workers' Compensation and Healthcare Insurance. Citation also wrote Contractors' General Liability policies covering construction defects and other losses. Citation was licensed to conduct business in California; Nevada; Arizona; South Dakota; and Washington. The "Claims Bar Date", or the final date to submit a claim against the Estate, was September 9, 1996.

The initial effort after liquidation was to transfer all covered claims to the insurance guaranty associations (primarily workers compensation and construction defect exposure) and to resolve the Estate's participation in a claims pooling arrangement. Additionally, the Estate assumed control of the reinsurance program and completed a run off of all treaties.

During 2009, the Estate's goal was to resolve all asset collections, determine final estate liabilities (subject to ultimate tax exposure), file with the IRS an application for recognition of exemption, and position the Estate to make a final distribution.

The Estate's remaining objective is the resolution of its final tax liability (Citation is part of a consolidated tax group) and to distribute any remaining funds that are being held as a tax reserve in 2010.

Citation General Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$11,448,200	$11,500,000
Recoverable from reinsurers	86,600	86,600
Other assets	900	600
Total assets	11,535,700	11,587,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	5,869,000	1,615,800
Claims against policies, before distributions	17,956,600	17,961,600
Less distributions to policyholders	(17,132,700)	(17,132,700)
All other claims	1,812,600	1,812,600
Total liabilities	8,505,500	4,257,300
Net assets (deficiency)	$3,030,200	$7,329,900

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$254,900	$829,100
Salvage and other recoveries	600	25,000
Total income	255,500	854,100

Expenses	2008	2009
Loss and claims expenses	390,000	326,400
Administrative expenses	269,000	326,500
Total expenses	659,000	652,900
Net income (loss)	($403,500)	$201,200

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$8,744,200
Recoveries, net of expenses	19,888,500
Distributions	(17,132,700)
Monetary assets available for distribution	$11,500,000

Executive Life Insurance Company

Conservation Order: April 11, 1991
Liquidation Order: December 6, 1991

2009 Report

Executive Life Insurance Company ("ELIC") was placed into conservation in April 1991 primarily as a result of significant value declines in its high-yield investment portfolio. A comprehensive Rehabilitation Plan was adopted, heavily litigated and ultimately confirmed by the Court in 1993. As part of the Plan, ELIC policyholders could elect to either accept new coverage ("Opt-In") from Aurora National Life Assurance Company ("Aurora"), or to "opt-out" and surrender their policies for cash.

The California Insurance Commissioner, in his capacity as Rehabilitator, Conservator, and Liquidator of the ELIC estate, commenced a civil action in 1999 against various defendants, alleging that they had fraudulently and unlawfully obtained control over ELIC, its former bond portfolio and insurance assets, all in violation of federal and state laws prohibiting a foreign government-owned bank from acquiring control of a California insurance company. At the conclusion of the civil lawsuit, the court awarded net-restitution of $131,092,020, and the jury awarded $700 million for punitive damages in favor of the Commissioner. The court subsequently vacated the jury award of punitive damages. Defendants, Artemis et al, appealed the restitution award, while the Commissioner appealed the judge's decision to vacate the jury award.

On August 25, 2008, the U.S. Ninth Circuit Court of Appeals ruled to (1) vacate the district court's $131,092,020 net restitution award with leave to reinstate if warranted, at the close of a new damages phase trial, (2) affirm the district court's order vacating the jury's $700 million punitive damages award under California law, and (3) remand the case to the district court for a new damages phase trial limited to proffer the NOLHGA premise and a determination of damages (including punitive damages), if any, on that theory. Thelen Reid & Priest LLP, the law firm hired by the Commissioner to prosecute the original lawsuit has dissolved and as a result, the Commissioner has engaged the law firm of Shartsis Friese LLP to continue the litigation at the district court for a new damages phase trial; a hearing date was set for November 3, 2009,but the trial court has since vacated this date and a new hearing date is yet to be set.

Depending on the outcome of the trial, when the trial takes place, we anticipate that the party that does not prevail may embrace the opportunity to file an appeal, if that party does not agree with the court's decision. An appeal may delay the estate's final distribution and estate closure.

During 2008, the Bureau of State Audits ("BSA") audit of ELIC was completed. BSA made certain operational recommendations to assist with the continuing administration of ELIC and the Commissioner is pursuing those recommendations. Based on BSA's recommendation, the Commissioner is awaiting agreement from Aurora National Assurance Company, Inc. and the National Organization Life & Health Insurance Guaranty Association (NOLHGA) that allows the Commissioner to conduct a due diligence review of any future distribution to Aurora for ELIC opt in policyholders. During this same period and thereafter, the Indentured Trustee Policyholders, ("ELIC opt out

policyholders") filed an objection against the Commissioner's application to the conservation court seeking approval of CLO's internal administrative expenses incurred by the ELIC estate for the years 1997 to 2006, in the amount of approximately $9.8 million. For the year 2007, in the amount of $1,228,960 and from January to June 2008, in the amount of $473,639. On December 7, 2009, the court approved the Commissioner's internal administrative expenses from 1997 to June 2008, but disallowed the amount of $597, 254.65. On February 16, 2010, the court issued a Tentative Order approving the Commissioner's internal administrative expenses from July 2008 to December 2008.

On February 4, 2010, the Indentured Trustee Policyholders filed an appeal against the Order Granting Insurance Commissioner's Application for Approval of Internal Expenses for the Periods 1997 – December 31, 2006 and January 1, 2007 – June 30, 2008.

The Pennsylvania Superior Court ordered Pennsylvania Life & Health Insurance Guaranty Association ("PLHIGA") to make whole the losses of all Pennsylvania policyholders of ELIC and as a result of PLHIGA making supplemental payments, PLHIGA obtained an absolute assignment of all distributions the estate makes to those policyholders. The Commissioner's dispute with PLHIGA involves who receives the first dollar of estate distributions, PLHIGA or the policyholder. The Commissioner and PLHIGA have yet to settle this dispute which to date remains outstanding. Hopefully, this dispute would be amicably resolved as soon as possible. Previously allotted policyholder funds are being held until resolution of this issue.

NOLHGA has informed the Commissioner that in the 1995/1996 timeframe distributions made to policyholders were mischaracterized as Article 10 distributions versus Article 17 distributions. The Commissioner and NOLHGA have settled this matter and in accordance with the pertinent provisions of the ELIC Enhancement Agreement, these funds will be distributed to NOLHGA at the next scheduled ELIC distribution.

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 Artisinale 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 hearing on 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 hearing 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 intends to distribute the MAAF funds in the third quarter of 2010. This trust however, continues to remain open to effect distributions to Opt-Out policyholders if the Commissioner is successful in the retrial.

Holdback Trust

This trust is a grantor trust of Aurora National Life Assurance Company ("Aurora") administered by the Commissioner as trustee. It was created in 1994 to hold ELIC assets while certain litigation challenges to the terms of the Rehabilitation Plan were pending an appeal. When all legal challenges were resolved, all funds in the Holdback Trust were distributed except for funds that were due to ELIC policyholders that could not be located. Since 1998, the Commissioner vigorously continued to attempt to locate the missing policyholders. In 2007, all remaining held funds were included within the Aurora AVI distribution. Presently the Holdback Trust is completing the escheatment of unclaimed funds to the policyholder's state of last record. Within California, the State Controller's Office ("SCO") received notification, researched addresses and communicated via letter to all individuals with unclaimed property in excess of $50. During a seven-and-one-half month period, if any policyholders are located, their funds will be paid. The remaining California funds were remitted to the SCO in November 2009 to accommodate the SCO regulations. Escheatment of funds to other states was completed in June 2009. The Holdback Trust is now scheduled to be closed by the end June, 2010. At that time, an application will be made to the court to terminate the trust and discharge the Commissioner as trustee.

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. Presently the FEC Trust is completing the escheatment of unclaimed funds to the policyholder's state of last record. Within California, the SCO will be sent notification of unclaimed property. They will research addresses and communicate via letter to all individuals with unclaimed property in excess of $50. During a seven and one half month period, if any policyholders are located, their funds will be paid. The remaining California funds were remitted to the SCO in December 2009, to accommodate the SCO regulations. 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. Upon the application of those funds, the Commissioner plans to finally close the trust by June 30, 2010. 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.

Executive Life Insurance Company
ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments, unrestricted	$43,125,200	$35,798,000
Restricted investments, NOLHGA	9,379,900	9,387,100
Restricted investments, Opt-In Only	490,100	295,700
Restricted investments, Aurora-Penn	5,878,200	5,894,600
Other assets	1,653,400	1,605,800
Total assets	60,526,800	52,981,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	8,167,000	8,484,800
Policyholders liability [8]	5,241,748,200	5,469,371,500
All other claims	428,800	428,800
Total liabilities	5,250,344,000	5,478,285,100
Net assets (deficiency)	($5,189,817,200)	($5,425,303,900)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$3,758,400	$2,669,000
Total income	3,758,400	2,669,000

Expenses	2008	2009
Post-liquidation Federal income tax		229,400
Administrative expenses	2,073,200	10,302,900
Accrued interest on policyholder liability	227,623,300	227,623,300
Total expenses	229,696,500	238,155,600
Net income (loss)	($225,938,100)	($235,486,600)

CHANGE IN MONETARY ASSETS [9]

Beginning monetary assets at takeover	$112,111,400
Recoveries, net of expenses	676,540,000
Distributions	(737,275,900)
Monetary assets	$51,375,500

[8] *In preparation for the eventual final distribution and closing of the estate, a detailed review of the liability to policyholders was performed based on examination of the Modified Rehabilitation Plan and relevant judicial decisions. In 2009 the Estate corrected its policyholder liability to reflect the actual liability, as established by the Court in 1993. This correction was made as a prior period adjustment of $2,752,730,200 to net asset balance as of December 31, 2007. In addition, interest of $227,623,300 was accrued in 2008 and 2009. The revised policyholder liability balance includes accrued but unpaid interest owed to former ELIC policyholders of approximately $2.0 billion and $2.2 billion as of December 31, 2008 and 2009, respectively.*

This revision is consistent with the methodology specified in the Rehabilitation Plan, approved by the Court, which has been used to make all distributions from the ELIC estate. The revision will have no impact on individual policyholders or their right to a proportionate share of any future distributions.

[9] *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, 2009.*

ELIC Holdback Trust

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$1,776,700	$344,700
Total assets	1,776,700	344,700

Liabilities	12/31/2008	12/31/2009
Unclaimed funds payable	$1,147,900	$0
Reserve for administrative expenses	628,800	344,700
Total liabilities	1,776,700	344,700

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income and Expenses	2008	2009
Investment income	$33,600	$45,806
Administrative expenses	100	343,558
Net income (loss)	$33,500	($297,752)

ELIC Opt Out Trust

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$21,349,500	$21,184,100
Total assets	21,349,500	21,184,100

Liabilities	12/31/2008	12/31/2009
Secured claims	$17,814,900	$18,043,800
Unclaimed funds payable	2,477,700	2,476,700
Reserve for administrative expenses	1,056,900	663,600
Total liabilities	21,349,500	21,184,100

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income and Expenses	2008	2009
Investment income	$429,700	$39,000
Administrative expenses	74,000	120,100
Net income (loss)	$355,700	($81,100)

ELIC FEC Litigation Trust

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$855,200	($201,500)
Receivable from Insurance Fund	215,700	298,700
Total assets	1,070,900	97,200

Liabilities	12/31/2008	12/31/2009
Secured claims	$95,600	$97,200
Unclaimed funds payable	975,300	
Total liabilities	1,070,900	97,200

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income and Expenses	2008	2009
Investment income	$16,800	$33,494
Administrative expenses		144,831
Net income (loss)	$16,800	($111,337)

Fremont Indemnity Company

Conservation Order: June 04, 2003
Liquidation Order: July 02, 2003

2009 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.

After the initial liquidation there was a significant amount of coordination to get all open covered claims to the insurance guaranty associations. The Estate also faced significant self-insured and large deductible programs to be administered and resolved. At the time of insolvency, the Estate had nearly $1 billion in reinsurance recoverable reserves on the books. A significant number of the Fremont Reinsurance Department staff were retained to help plan and manage the long-term run off of the program.

In addition to asset recoveries, the Estate filed various lawsuits seeking to recover assets or damages from the parent entity, former officers and directors as well as third parties. The breach of fiduciary duty complaint filed against the former officers and directors went to trial in October 2008 and both sides completed their closing arguments and briefs in March of 2009. Prior to the judge entering his ruling, the Estate entered global settlement discussions with FGC and the D&O defendants.

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).

Finally, the Estate reached a court mediated settlement of all claims associated with the bill review dispute with Concentra for a cash payment of $3.2 million. With this

resolution all of the Estate's pending litigation is now settled, subject to collections from the FGC bankruptcy estate.

The Estate continues to bill and collect on active reinsurance treaties, as well as seeking commutations where advantageous. It was determined in 2008 to consolidate the Los Angeles reinsurance operations of the estate into the CLO's San Francisco office in 2009. The closure of the Los Angeles reinsurance unit was completed on June 30, 2009. 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 completed its sixth early access distribution in 2009, and continues to refine the magnitude of the policyholder claims that are not covered by the guaranty associations.

The Estate anticipates releasing its seventh early access distribution during 2010, or it may seek to make an interim distribution to all approved Policyholder Class creditors if the non-covered exposure can be reliably quantified.

Fremont Indemnity Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$134,918,400	$103,111,700
Recoverable from reinsurers	168,264,100	180,438,900
Other assets	59,939,600	56,502,600
Total assets	363,122,100	340,053,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	24,464,000	24,261,300
Claims against policies, before distributions	2,397,240,800	2,749,754,800
Less distributions to policyholders	(810,153,300)	(859,789,200)
All other claims	393,751,700	395,607,400
Total liabilities	2,005,303,200	2,309,834,300
Net assets (deficiency)	($1,642,181,100)	($1,969,781,100)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$5,532,900	$9,417,100
Litigation recoveries	265,900	40,428,700
Other recoveries	15,412,000	8,370,500
Total income	21,210,800	58,216,300

Expenses	2008	2009
Loss and claims expenses	148,144,700	375,218,300
Administrative expenses	12,458,400	9,261,600
Total expenses	160,603,100	384,479,900
Net income (loss)	($139,392,300)	($326,263,600)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$434,855,900
Recoveries, net of expenses	528,045,000
Distributions	(859,789,200)
Monetary assets available for distribution	$103,111,700

Fremont Life Insurance Company

Conservation Order: June 05, 2008

2009 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 conservation estate continues to seek release of certain protective deposits to help fund the cost to complete the assumption process. To date the conservation estate has limited but sufficient funds to pay all court mandated premium surcharges to certain policyholders upon receipt of the proper demand as well as maintain the required books and records of the estate. Subject to gaining release of the deposits, it is expected to require most of 2010 to complete the formal assumption process and to resolve the remaining contractual disputes associated with litigation existing at the time of conservation.

The stock of Fremont Life was conveyed to the Fremont Indemnity insolvency estate together with $100,000 as part of the overall global settlement between Fremont Indemnity and FGC's bankruptcy estate. The ultimate goal of the conserved estate is to complete the risk transfer, resolve the few remaining disputes, and close the conservation.

Fremont Life Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$1,458,200	$1,296,800
Other assets	209,300	209,300
Total assets	1,667,500	1,506,100

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	153,000	32,700
All other claims	258,500	1,408,500
Total liabilities	411,500	1,441,200
Net assets (deficiency)	$1,256,000	$64,900

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$40,900	($67,000)
Litigation recoveries		100,000
Salvage and other recoveries	173,100	96,100
Total income	214,000	129,100

Expenses	2008	2009
Loss and claims expenses	9,800	
Administrative expenses	171,400	170,300
Total expenses	181,200	170,300
Net income (loss)	$32,800	($41,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$1,443,100
Recoveries, net of expenses	(146,300)
Monetary assets available for distribution	$1,296,800

Frontier Pacific Insurance Company

Conservation Order: September 7, 2001
Liquidation Order: November 30, 2001

2009 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. However, FIC has refused to honor approximately $19.1 million in reinsurance obligations owed to FPIC. In addition, FIC has improperly retained approximately $190,000 which FIC collected on FPIC's behalf from Everest Reinsurance Company and has not provided FPIC with the necessary documents or assistance to collect on a federal income tax recoverable of approximately $5.3 million. Over the past eight years, the Commissioner has sought the cooperation of the New York Liquidation Bureau in marshalling these assets, but that cooperation has not been forthcoming. Thus, the Commissioner commenced litigation against FIC in the New York court overseeing the FIC rehabilitation, to determine whether FIC is in a financial position to honor any portion of FPIC's claims. As of March 3, 2010, both parties have filed the necessary briefs and await the Court's decision.

In light of FIC's failure to cooperate, the Liquidator is no longer collaborating with the New York Liquidation Bureau to reconcile and collect on group reinsurance programs that were historically maintained by FIC. FPIC's largest reinsurance relationship is with National Indemnity Company ("NICO"), a subsidiary of Berkshire Hathaway, Inc., which refuses to pay FPIC, asserting that it may offset against FPIC's claims over $40 million

in premium owed by FIC, for which NICO released FIC, in a transaction to which FPIC was not a party.

Unable to reach a reasonable resolution to the NICO dispute, the Liquidator filed a Declaratory Relief action to determine the Estate's obligations under FPIC's reinsurance relationship with NICO. The Court granted NICO's request to stay the action until FPIC and NICO arbitrate their dispute. Thereafter, the Commissioner, in his capacity as liquidator of FPIC, negotiated a Submission Agreement with NICO to resolve all outstanding issues between the parties in a single arbitration proceeding. A panel of three experienced reinsurance arbitrators has been chosen, and will meet later in April with the parties and counsel to set a schedule for the arbitration.

Resolution of the NICO and FIC reinsurance relationships will be a significant step toward positioning the Estate for a final distribution and closure.

Frontier Pacific Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$19,220,200	$19,335,900
Recoverable from reinsurers	46,737,600	43,956,900
Other assets	1,450,100	1,419,600
Total assets	67,407,900	64,712,400

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	791,800	2,638,000
Claims against policies, before distributions	53,653,800	53,908,900
All other claims	22,675,000	22,675,000
Total liabilities	77,120,600	79,221,900
Net assets (deficiency)	($9,712,700)	($14,509,500)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$384,100	$1,096,900
Salvage and other recoveries	26,700	285,900
Total income	410,800	1,382,800

Expenses	2008	2009
Loss and claims expenses	700,600	5,199,000
Administrative expenses	915,900	980,200
Total expenses	1,616,500	6,179,200
Net income (loss)	($1,205,700)	($4,796,400)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$18,531,900
Recoveries, net of expenses	804,000
Monetary assets available for distribution	$19,335,900

Golden Eagle Insurance Company

Conservation Order:	**January 31, 1997**
Rehab./Liquidation Plan Approved:	**August 4, 1997**
Liquidation Order:	**February 18, 1998**

2009 Report

The Golden Eagle Insurance Company Liquidating Trust ("The Trust") was created and approved by the Superior Court as a neutral mechanism to manage the liquidation of Golden Eagle Insurance Company. The Trust was created as of the entry of the Liquidation Order. The Liquidation Order does not contain a formal finding of insolvency, and thus the Insurance Guaranty Associations have not been triggered, and no bar date has been set for the filing of claims covered under a Golden Eagle policy, which claims will continue to be received, adjusted and paid in the ordinary course of the run-off of Golden Eagle's policyholder liabilities.

The Trust was responsible for the management of third-party claim administrators and reinsurers (affiliates of Liberty Mutual Insurance Company) who were and continue to be responsible for the adjustment and payment of covered policyholder claims. The Trust also managed the residual assets of the liquidated 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.

As part of the Rehabilitation Plan, the Trust purchased sufficient reinsurance coverage to cover the remaining covered insurance policy exposures, including liabilities under both workers' compensation and other property and casualty policies. In 2006, the Trust and the Commissioner prepared and implemented a final closing plan. All affairs associated with the discontinued insurance operations and monitoring of the claims run off plan have been transferred to the CLO. The Trust was officially terminated and closed on November 30, 2006.

As all remaining policyholder claims are being administered and paid under an indemnity reinsurance agreement with Liberty Mutual affiliates, the estate will seek to transfer the remaining risk via novation or the equivalent. Until the entire remaining exposure is 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, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$2,031,600	$1,923,800
Total assets	2,031,600	1,923,800

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	1,100	300
Total liabilities	1,100	300
Net assets (deficiency)	$2,030,500	$1,923,500

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$54,800	($4,800)
Salvage and other recoveries	11,900	2,300
Total income	66,700	(2,500)

Expenses	2008	2009
Administrative expenses	85,700	104,500
Total expenses	85,700	104,500
Net income (loss)	($19,000)	($107,000)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover [10]	$2,029,000
Recoveries, net of expenses	(105,200)
Monetary assets available for distribution	$1,923,800

[10] *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: **TBD**

2009 Report

Golden State Mutual Life Insurance Company, (Golden State), is 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.

In August 2009, Golden State filed a Quarterly Statement as required by the Insurance Code, showing its financial condition as of June 30, 2009. The Quarterly Statement indicated that Golden State had 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, a circumstance that indicates Golden State was impaired. Consequently, Golden State was placed into conservation on September 30, 2009.

Since September 30, 2009 the Conservator's staff has managed Golden State's day-to-day operations, marshaled Golden State's assets and attempted to reduce Golden State's expenses and liabilities. Immediately following the placement of Golden State in Conservation, a number of interested parties inquired as to the process of determining the appropriate remedy for Golden State. The Conservator met or spoke with all who were interested.

Based on Golden State's financial condition and its operational capabilities, the Conservator determined that the business operations of Golden State were not sustainable and 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.

On November 24, 2009, the Conservator mailed forty-one solicitation letters to life insurance companies in an attempt to sale/merge Golden State into a financially strong life insurance company or by having a financially strong life insurance company assume the policies of Golden State in exchange for a ceding commission to be used to mitigate the non-policyholder liabilities of Golden State. The Conservator received responses from thirteen interested parties and mailed RFP ("Request for Proposal") packages to prospective bidders on December 14, 2009. Of the thirteen interested parties, seven groups scheduled due diligence reviews during the month of January, 2010. The deadline for submitting bids was January 29, 2010 and the Conservator received five bids for the sale/merger of Golden State or the assumption of Golden State's policies.

During the week of February 1-5, 2010, the Conservator contacted the 5 bidders to clarify aspects of their bids in an attempt to compare the strengths and weaknesses of each bid. The Conservator spent three weeks evaluating the bids according to the selection criteria established in the RFP. The selection criteria included the following:

- Whether the potential bidder seeks to acquire all or less than all of the insurance business described in the RFP.
- Whether the potential bidder is currently licensed in the jurisdictions in which the policy, contract and certificate owners of GSM reside.
- Whether the potential bidder is willing to accept GSM's bonds, stocks and mortgage loans.
- The size, financial strength and ratings of the potential bidder.
- Whether the potential bidder would seek policy restructuring.
- The potential bidder's experience in administering the types of business to be assumed and the fit/compatibility of the business with the potential bidder's existing business.
- Financial and legal requirements of the proposal, including the amount of assets (net of ceding commissions) required to be transferred to the bidder.

Based on the Conservator's review of the 5 bids that were submitted, it was recommended that the bid of IA American Life Insurance Company be accepted. IA American is a Georgia domiciled life insurance Company rated A- by A.M. Best. IA American is owned by Industrial Alliance Insurance and Financial Services, the fourth largest Canadian life insurer.

2010 Goals

- The Conservator anticipates filing a rehabilitation plan, assumption reinsurance agreement and service agreement between Golden State in Conservation and IA American Life Insurance Company with the California Superior Court during the month of April for approval.
- The Conservator will ask for a June, 2010 hearing date for approval of the assumption reinsurance agreement after appropriate notices have been given to all interested parties.
- The assumption reinsurance transaction, subject to approval by the California Superior Court, will close during August, 2010.
- The retained Golden State estate will petition the California Superior Court for an order of liquidation to invoke the priority of claim requirements of Insurance Code 1033 by September 30, 2010.
- The remaining on-going operations of Golden State Mutual Life Insurance Company will be discontinued as of December 31, 2010.

Golden State Mutual Life Insurance Company

ASSETS AND LIABILITIES

Assets	9/30/2009[11]
Cash and investments	$72,139,200
Recoverable from reinsurers	25,900
Other assets	2,366,200
Total assets	74,531,300

Liabilities	9/30/2009[11]
Policyholder claims	$71,078,700
Other claims	4,236,200
Total liabilities	75,314,900
Net assets (deficiency)	($783,600)

INCOME AND EXPENSES

Income	9/30/2009
Investment income	$2,560,000
Premium income	8,367,000
Other income	179,900
Total income	11,106,900

Expenses	9/30/2009
Loss and claims expenses	$13,204,500
Dividends to policyholders	70,400
Realized capital loss	80,500
Total expenses	13,355,400
Net income (loss)	($2,248,500)

[11] *Assets and liabilities of Golden State Mutual and its operating income and expenses have been audited using statutory basis of accounting as of 9/30/2009 when it was placed under a Conservation Order.*

HIH America Comp. & Liability Insurance Company

Conservation Order: **March 30, 2001**
Liquidation Order: **May 8, 2001**

2009 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 resolution of the various affiliated relationships has taken considerably longer than initially anticipated due to the fact many of the HIH affiliates, including the parent corporation, were determined to be insolvent and placed under the supervision of other regulators.

Shortly after liquidation, the Estate identified a potential legal dispute with a service provider over contractual service obligations. After numerous attempts to amicably resolve the issue, a formal demand for arbitration was served upon the vendor in 2006. The arbitration was concluded in June of 2007 with the Estate's final award being confirmed on December 4, 2007. The arbitration was settled in full for $1.485 million in January 2008.

The inter-company relationship with the Hawaii affiliate has been resolved through a Re-Designation Agreement and the payment of approximately $8 million to HIH. HIH Hawaii and the Estate have sought and received approvals in their respective liquidation courts. Settlement proceeds and remaining administrative reimbursements were transferred to the Estate.

The Estate's immediate goal is to resolve the final inter-company balance with the Australia parent company, collect the final reinsurance recoveries in 2010, and seek to release a final distribution by 2011.

HIH America Comp & Liability Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$48,413,400	$60,209,600
Recoverable from reinsurers	1,994,700	2,014,100
Other assets	20,764,500	11,059,400
Total assets	71,172,600	73,283,100

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	246,300	1,800
Claims against policies, before distributions	674,214,700	721,916,800
Less distributions to policyholders	(279,669,300)	(278,087,900)
All other claims	1,399,700	923,800
Total liabilities	396,191,400	444,754,500
Net assets (deficiency)	($325,018,800)	($371,471,400)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$907,800	$3,459,300
Litigation recoveries	1,485,100	
Salvage and other recoveries	1,990,800	1,492,800
Total income	4,383,700	4,952,100

Expenses	2008	2009
Loss and claims expenses	31,097,300	52,861,800
Administrative expenses	582,400	403,800
Total expenses	31,679,700	53,265,600
Net income (loss)	($27,296,000)	($48,313,500)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$147,637,800
Recoveries, net of expenses	190,659,700
Distributions	(278,087,900)
Monetary assets available for distribution	$60,209,600

Great States Insurance Company

Conservation Order: **March 30, 2001**
Liquidation Order: **May 8, 2001**

2009 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 also had a significant reinsurance program that was put into run off after liquidation. One major reinsurance contract remains with Munich/Am Re; and a commutation is being pursued. The Estate's primary goal is to resolve collections under a surety bond issued by American Home Assurance originally pledged as a statutory deposit.

Once all reinsurance assets are recovered, the Estate will determine final policyholder liability and seek a final distribution in 2011.

Great States Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$6,772,200	$7,064,600
Recoverable from reinsurers	10,590,600	10,590,600
Total assets	17,362,800	17,655,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	24,400	17,000
Claims against policies, before distributions	79,800,600	85,041,800
Less distributions to policyholders	(10,151,300)	(10,154,800)
All other claims	11,917,600	11,917,600
Total liabilities	81,591,300	86,821,600
Net assets (deficiency)	($64,228,500)	($69,166,400)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$116,600	$447,000
Salvage and other recoveries	67,900	(293,000)
Total income	184,500	154,000

Expenses	2008	2009
Loss and claims expenses	6,523,200	4,897,900
Administrative expenses	237,200	194,000
Total expenses	6,760,400	5,091,900
Net income (loss)	($6,575,900)	($4,937,900)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$7,889,700
Recoveries, net of expenses	9,329,700
Distributions	(10,154,800)
Monetary assets available for distribution	$7,064,600

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

2009 Report

The insolvency of Mission Insurance Company and affiliated insurers was the largest Property and Casualty insurer failure at the time of its conservation. The Mission Companies wrote complicated Primary, Excess, and Surplus insurance and reinsurance, much of which covers long-term exposure with losses developing over decades of time.

The Mission group of companies consisted of five affiliates: Mission Insurance Company ("MIC"), Mission National Insurance Company ("MNIC") and Enterprise Insurance Company ("EIC") which are California-domiciled companies. Holland-America Insurance Company ("HAIC") and Mission Reinsurance Corporation ("MRC") are domiciled in Missouri. HAIC wrote Property &Casualty business while MRC reinsured Property & Casualty business. These companies are direct or indirect subsidiaries of the Mission Insurance Group, Inc., which was later renamed as Danielson Holding Corporation ("DHC"), now known as Covanta Holding Corporation.

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 2008 additional disbursements made to 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.

Distributions to claimants in 2008 included the payment of both cash and stock. Both the Mission and Mission National estates held stock for the benefit of its claimants. In accordance with the court-approved allocation methodology, $32 million worth of Covanta shares were distributed to Mission and Mission National claimants. Additionally, the Mission estate distributed $28 million to its general creditors, and Mission National distributed $93 million as interest to its covered policyholder class.

The Mission estates file status conference reports on a regular quarterly interval. As final assets are recovered and tax reserves released, additional distributions to the claimants will be scheduled for 2010.

The collective Estate's goal is to efficiently advance the remaining reinsurance and asset collections and distribute available funds in accordance with the closing plan.

The Enterprise estate will seek to obtain court approval in 2010 to release another payment to its general creditors. Both the Mission and Mission National estates will also evaluate and seek court approval for a 2010 release.

Mission Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$88,859,500	$94,423,500
Recoverable from reinsurers	48,414,900	21,586,400
Other assets	78,083,400	79,798,100
Total assets	215,357,800	195,808,000

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	79,337,800	79,398,300
Claims against policies, before distributions	846,832,600	846,832,600
Less distributions to policyholders	(846,629,600)	(846,629,600)
All other claims	256,851,600	256,851,600
Total liabilities	336,392,400	336,452,900
Net assets (deficiency)	($121,034,600)	($140,644,900)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$3,581,200	$5,966,000
Debt forgiveness income	915,746,800	
Salvage and other recoveries	1,078,300	233,200
Total income	920,406,300	6,199,200

Expenses	2008	2009
Loss and claims expenses	206,512,600	25,067,700
Administrative expenses	1,326,200	739,800
Total expenses	207,838,800	25,807,500
Net income (loss)	$712,567,500	($19,608,300)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION [12]

Beginning monetary assets at takeover	$133,667,000
Recoveries, net of expenses	1,014,748,400
Distributions	(1,053,991,900)
Monetary assets available for distribution	$94,423,500

[12] *Subsequent to the release of the 2008 financial statements, the Mission [Mission National] estate revised certain reinsurance recoverable and related balances as of 12/31/2008 to account for the restoration of latent deficiency claims previously written off.*

Mission National Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$18,120,400	$21,853,600
Recoverable from reinsurers	6,989,600	5,119,900
Other assets	147,300	120,700
Total assets	25,257,300	27,094,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	17,743,000	17,754,900
Claims against policies, before distributions	596,098,500	596,098,500
Less distributions to policyholders	(499,606,700)	(499,606,700)
All other claims	16,838,100	16,838,100
Total liabilities	131,072,900	131,084,800
Net assets (deficiency)	($105,815,600)	($103,990,600)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$1,192,900	$1,251,100
Debt forgiveness income	75,397,400	
Salvage and other recoveries	49,300	57,200
Total income	76,639,600	1,308,300

Expenses	2008	2009
Loss and claims expenses	220,921,400	(678,700)
Administrative expenses	397,700	162,200
Total expenses	221,319,100	(516,500)
Net income (loss)	($144,679,500)	$1,824,800

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION [13]

Beginning monetary assets at takeover	$18,289,000
Recoveries, net of expenses	530,248,700
Distributions	(526,684,100)
Monetary assets available for distribution	$21,853,600

[13] *Subsequent to the release of the 2008 financial statements, the Mission [Mission National] estate revised certain reinsurance recoverable and related balances as of 12/31/2008 to account for the restoration of latent deficiency claims previously written off.*

Enterprise Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$6,319,600	$1,595,700
Total assets	6,319,600	1,595,700

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	1,094,600	1,241,600
Claims against policies, before distributions	120,573,400	120,573,400
Less distributions to policyholders	(120,573,400)	(120,573,400)
All other claims	35,632,800	30,780,900
Total liabilities	36,727,400	32,022,500
Net assets (deficiency)	($30,407,800)	($30,426,800)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$69,800	$242,300
Salvage and other recoveries	1,669,800	200
Total income	1,739,600	242,500

Expenses	2008	2009
Loss and claims expenses	(2,613,400)	76,600
Administrative expenses	16,100	184,800
Total expenses	(2,597,300)	261,400
Net income (loss)	$4,336,900	($18,900)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$3,281,000
Recoveries, net of expenses	124,267,200
Distributions	(125,952,500)
Monetary assets available for distribution	$1,595,700

Municipal Mutual Insurance Company

Supervision Agreement Date: August 18, 2003
Liquidation Order: October 31, 2006

2009 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 CIGA. This order will allow CIGA to accept policyholder claims relating to latent exposures into the future.

Collection of reinsurance is the only reason the Estate is open. The CLO is collecting balances due and is current in billing. We have begun actuarial evaluations necessary to commute all remaining reinsurance treaties. The reinsurers appear amenable to commutations.

The Estate collected $377,907 of reinsurance in 2009 and has initiated commutation negotiations of all remaining contracts.

Municipal Mutual Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$1,245,100	$1,646,300
Recoverable from reinsurers	1,137,400	4,778,200
Total assets	2,382,500	6,424,500

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	24,500	25,200
Claims against policies, before distributions	8,742,700	10,542,100
Total liabilities	8,767,200	10,567,300
Net assets (deficiency)	($6,384,700)	($4,142,800)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$7,800	$95,300
Salvage and other recoveries	4,400	127,700
Total income	12,200	223,000

Expenses	2008	2009
Loss and claims expenses	510,300	(2,091,600)
Administrative expenses	88,200	72,900
Total expenses	598,500	(2,018,700)
Net income (loss)	($586,300)	$2,241,700

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$920,200
Recoveries, net of expenses	726,100
Monetary assets available for distribution	$1,646,300

National Automobile & Casualty Insurance Company

Conservation Order: **March 15, 2002**
Liquidation Order: **April 23, 2002**

2009 Report

National Automobile & Casualty Insurance Company ("NACIC") specialized in Private Passenger, Automobile Liability, Physical Damage, Homeowner, Fire, Liability, Common Carrier Liability, Surety, and other miscellaneous classes of insurance. NACIC was licensed to write business in eight states. Since liquidation, all guaranty associations continue to pay and report on covered claims. The "Claims Bar Date", or the final date to submit a claim against the Estate, was December 20, 2002.

At liquidation, significant efforts were required to properly place all covered claims with the respective guaranty associations. Given the myriad of polices written, the transfer was considerable and took an extended period of time. Also at the time of liquidation, the company was completing the final stages of construction on a new home office in Arcadia. The building was appraised and sold in 2003.

In addition to the sale of the Arcadia building, the Estate also obtained court approvals for the sale of the legal title to National Automobile's charter and license documents, and the sale of reinsurance contracts known as AMI Reinsurance Contracts. The balance of the reinsurance program was placed in run-off.

During 2009, the Estate's goal was to finalize its total liability and complete a final distribution. These goals were accomplished.

The Estate's remaining objective is to escheat any unclaimed funds to the California State Controller's Office, and petition the Los Angeles Superior Court to close the Estate in 2010.

National Automobile and Casualty Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$24,731,100	$320,700
Total assets	24,731,100	320,700

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	289,800	20,700
Claims against policies, before distributions	22,143,400	23,427,800
Less distributions to policyholders	(391,500)	(23,427,800)
All other claims	5,055,800	
Total liabilities	27,097,500	20,700
Net assets (deficiency)	($2,366,400)	$300,000

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$465,700	$3,422,100
Salvage and other recoveries	(123,800)	360,900
Total income	341,900	3,783,000

Expenses	2008	2009
Loss and claims expenses	(39,300)	(1,610,900)
Administrative expenses	291,600	350,500
Total expenses	252,300	(1,260,400)
Net income (loss)	$89,600	$5,043,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$13,264,000
Recoveries, net of expenses	14,375,900
Distributions	(27,319,200)
Monetary assets available for distribution	$320,700

Pacific National Insurance Company

Conservation Order: **May 14, 2003**
Liquidation Order: **August 5, 2003**

2009 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 in only 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", or 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 and reinsurance collections.

During 2009, the Estate's goal was to finalize an actuarial study in 2009 and commence commutation proposals in 2010.

The Estate's immediate goal is to finalize commutations for asset collections and position the Estate for an interim distribution in 2010.

Pacific National Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$14,866,900	$17,307,300
Recoverable from reinsurers	9,285,500	19,300,900
Total assets	24,152,400	36,608,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	5,530,000	6,172,300
Claims against policies, before distributions	108,126,500	119,976,100
Less distributions to policyholders	(23,416,400)	(23,416,400)
All other claims	239,300	246,400
Total liabilities	90,479,400	102,978,400
Net assets (deficiency)	($66,327,000)	($66,370,200)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$259,400	$1,017,000
Salvage and other recoveries	758,400	1,020,900
Total income	1,017,800	2,037,900

Expenses	2008	2009
Loss and claims expenses	6,349,000	1,857,300
Administrative expenses	255,600	223,800
Total expenses	6,604,600	2,081,100
Net income (loss)	($5,586,800)	($43,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$36,519,100
Recoveries, net of expenses	4,204,600
Distributions	(23,416,400)
Monetary assets available for distribution	$17,307,300

Sable Insurance Company

Conservation Order: **May 10, 2001**
Liquidation Order: **July 17, 2001**

2009 Report

Sable Insurance Company is a California-domiciled wholly-owned subsidiary of Sable Insurance Holding Company. Sable Insurance Company wrote Workers' Compensation and Property and Casualty insurance and was licensed to write business in California, Illinois, Indiana, and Missouri. The "Claims Bar Date", or the final date to submit a claim against the Estate, was June 30, 2002.

A significant portion of Sable's assets consist of reinsurance receivables which are not immediately collectible due to the insolvency of a primary reinsurer, Reliance.

The Estate's primary objectives are to resolve all reinsurance recoveries for estate closure in 2011. The Estate continues to pursue collection of final reinsurance balances and will consider selling or writing off the final accounts if balances cannot be commuted. An interim distribution has been planned to occur at the beginning of 2010 for approximately $15 million in disbursements. The cost to keep the Estate open beyond the immediate estate plan may not be justified.

Sable Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$15,116,200	$15,800,700
Recoverable from reinsurers	291,100	252,500
Other assets	4,700	
Total assets	15,412,000	16,053,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	1,558,200	15,500
Claims against policies, before distributions	52,306,000	50,131,000
Less distributions to policyholders	(6,661,400)	(6,661,400)
All other claims	185,800	191,000
Total liabilities	47,388,600	43,676,100
Net assets (deficiency)	($31,976,600)	($27,622,900)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$284,100	$857,400
Salvage and other recoveries	158,200	283,400
Total income	442,300	1,140,800

Expenses	2008	2009
Loss and claims expenses	1,587,600	(1,926,100)
Administrative expenses	246,900	291,200
Total expenses	1,834,500	(1,634,900)
Net income (loss)	($1,392,200)	$2,775,700

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$17,472,300
Recoveries, net of expenses	4,989,800
Distributions	(6,661,400)
Monetary assets available for distribution	$15,800,700

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

2009 Report

On March 6, 2000, the Los Angeles County and Sacramento County Superior Courts 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 Los Angeles County Superior Court ordered and appointed the Commissioner to serve as conservator of a fifth workers' compensation insurance company named Commercial Compensation Casualty Company (collectively the "Insurance Estates"). In his capacity as Conservator, the Insurance Commissioner obtained title to and possession of all the property and assets of the Insurance Estates, the value of which exceeded $1.4 billion.

On April 26, 2000, Superior National Insurance Group, Inc., Business Insurance Group, Inc., the parent companies to the Insurance Estates (collectively "Debtors") filed voluntary petitions for relief under chapter 11 in United States Bankruptcy Court. Both companies continued to operate as Debtors in Possession.

On September 26, 2000, Los Angeles County Superior Court found that each of the Insurance 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 Insurance Estates was to marshal assets, pay claims and resolve the vast business affairs as efficiently as possible. In this regard, the Liquidator consolidated the Insurance Estates' operations into the offices of the Conservation and Liquidation Office (San Francisco) in September 2003.

In addition to the Conservation and Liquidation Office, the Liquidator retained services of the employees of the insolvent companies to complete various aspects of the liquidation process. These services were supplemented by specialized vendors, contractors, consultants and attorneys. Non-litigation legal services were provided by the California Department of Insurance's Legal Division. The Office of the Attorney General is the Liquidator's primary litigation counsel. Both sets of attorneys were supplemented by private counsel with expertise in specialized areas of the law.

Surety Litigation

Prior to conservation, the Superior National companies posted seven Workers' Compensation Bonds issued by four surety companies to partially satisfy the Superior National companies' liability to pay workers' compensation awards issued by the Workers' Compensation Appeals Board ("WCAB"). The bonds were issued pursuant to former Insurance Code § 11690 et seq., which was repealed as of January 1, 2003.

The sureties agreed that in the event the Superior National companies fail to pay awards rendered against them by the WCAB within 30 days after an award becomes final, the sureties collectively will pay up to $94 million of such awards.

Starting in June 2000 (prior to liquidation), the Department of Insurance demanded that the sureties pay their respective shares of awards, but they have refused. On September 23, 2003, in the Los Angeles Superior Court, the Commissioner sued each of the sureties for payment of benefits attributable to the WCAB awards, plus interest and attorneys' fees.

All four surety cases have now been settled. In aggregate, the Commissioner recovered $88.5 million for the benefit of injured workers paid by CIGA.

U.S. Life Arbitration

On February 18, 2007, the arbitration panel hearing the U.S. Life dispute entered its Final Award finding that all amounts billed to U.S. Life are properly ceded and due, and ordered payment of $443,515,724, plus interest at the daily rate of $81,242.36 computed from January 1, 2007.

A judgment was entered on June 25, 2007 confirming the Final Arbitration Award but amending the interest rate to the federal interest rate from date of entry of Judgment. U.S. Life appealed the judgment to the Ninth Circuit Appellate Court and posted a surety bond in the amount of $600 million to preclude the Commissioner from executing on judgment. The Appeal was heard on November 19, 2008 and on January 4, 2010, the Ninth Circuit Court of Appeals issued its opinion affirming the US District Court's decision upholding the arbitration awards. On January 19, 2010, US Life filed its motion to reconsider and reconsider en banc. On March 1, 2010, the Commissioner filed an Appellee's Answer to Petition for Rehearing and Rehearing En Banc. On March 19, 2010 the court denied US Life's petition.

US Life now has ninety days to file a petition for appeal with the United States Supreme Court. With interest charges accruing until all appeals are exhausted, the judgment is now more than $517 million and as noted previously secured by a $600 million surety undertaking.

Since US Life refused to make any payments pursuant to the reinsurance contract while its appeal is pending, the Commissioner filed an application and obtained an order authorizing the Commissioner to draw $53 million from U.S. Life's Special Schedule P Deposit. Make a distribution to the California Insurance Guarantee Association (CIGA) to reimburse CIGA for its compensable workers' compensation insurance claims made to injured workers under policies issued by the SNICIL companies, which policies are reinsured by U.S. Life.

2010 Outlook

Under the most optimistic estimates, SNICL will not have sufficient assets to fully pay the policyholder claims. Consequently, once asset recoveries and liabilities are determined, the Estate will seek court approval not to consider any potential claims below the policyholder class. The "Claims Bar Date", or the final date to submit a claim against the Estates, was May 25, 2001.

The Estate is working to determine all non-guaranty association policyholders' liabilities by year-end 2010. The Estate's ultimate goal is to resolve its reinsurance program, complete final asset recoveries and position the Estate for closure.

It is anticipated that resolution of the U.S. Life arbitration case will be in the fourth quarter of 2010. It is expected that U.S. Life will have exhausted all its appeal rights and the judgment entered in favor of the Estate will be final. US Life will be required to pay the judgments shortly after. In the unlikely event that US Life refuses to pay the judgment, the Commissioner will have available to him the right to drawdown on U.S. Life's $600 million supersedeas bond.

California Compensation Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$41,687,300	$48,874,700
Recoverable from reinsurers	378,240,400	345,272,400
Other assets	143,100	63,400
Total assets	420,070,800	394,210,500

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	28,390,000	21,821,800
Claims against policies, before distributions	1,745,533,800	1,900,929,600
Less distributions to policyholders	(441,217,600)	(472,100,600)
All other claims	120,683,500	119,760,000
Total liabilities	1,453,389,700	1,570,410,800
Net assets (deficiency)	($1,033,318,900)	($1,176,200,300)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$1,040,200	$2,740,100
Salvage and other recoveries	7,928,600	6,091,100
Total income	8,968,800	8,831,200

Expenses	2008	2009
Loss and claims expenses	169,373,200	156,482,500
Administrative expenses	2,321,900	1,743,900
Total expenses	171,695,100	158,226,400
Net income (loss)	($162,726,300)	($149,395,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$165,879,200
Recoveries, net of expenses	355,096,100
Distributions	(472,100,600)
Monetary assets available for distribution	$48,874,700

Combined Benefits Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$2,703,200	$2,646,300
Recoverable from reinsurers	12,064,400	11,039,600
Total assets	14,767,600	13,685,900

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	415,900	205,400
Claims against policies, before distributions	25,581,700	33,606,500
Less distributions to policyholders	(17,215,900)	(18,208,600)
All other claims	3,590,600	3,673,400
Total liabilities	12,372,300	19,276,700
Net assets (deficiency)	$2,395,300	($5,590,800)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$46,100	$158,900
Salvage and other recoveries	16,200	154,700
Total income	62,300	313,600

Expenses	2008	2009
Loss and claims expenses	(3,932,400)	8,377,400
Administrative expenses	89,300	132,400
Total expenses	(3,843,100)	8,509,800
Net income (loss)	$3,905,400	($8,196,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$11,115,400
Recoveries, net of expenses	9,739,500
Distributions	(18,208,600)
Monetary assets available for distribution	$2,646,300

Superior National Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$21,798,700	$19,863,400
Recoverable from reinsurers	184,940,400	175,917,700
Other assets	232,300	21,100
Total assets	206,971,400	195,802,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	7,123,700	4,991,300
Claims against policies, before distributions	730,358,600	828,057,400
Less distributions to policyholders	(164,251,500)	(187,172,400)
All other claims	28,747,300	28,751,800
Total liabilities	601,978,100	674,628,100
Net assets (deficiency)	($395,006,700)	($478,825,900)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$717,400	$1,083,000
Salvage and other recoveries	58,376,300	3,300,500
Total income	59,093,700	4,383,500

Expenses	2008	2009
Loss and claims expenses	34,237,600	89,656,200
Administrative expenses	1,030,200	647,800
Total expenses	35,267,800	90,304,000
Net income (loss)	$23,825,900	($85,920,500)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$68,622,300
Recoveries, net of expenses	138,413,500
Distributions	(187,172,400)
Monetary assets available for distribution	$19,863,400

Superior Pacific Casualty Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$6,632,900	$8,216,000
Recoverable from reinsurers	22,367,700	25,011,900
Other assets	400	
Total assets	29,001,000	33,227,900

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	1,648,900	76,900
Claims against policies, before distributions	169,027,700	198,889,300
Less distributions to policyholders	(30,600,400)	(30,586,800)
All other claims	68,312,700	60,548,700
Total liabilities	208,388,900	228,928,100
Net assets (deficiency)	($179,387,900)	($195,700,200)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$135,500	$482,500
Salvage and other recoveries	306,800	1,730,300
Total income	442,300	2,212,800

Expenses	2008	2009
Loss and claims expenses	6,509,200	19,712,100
Administrative expenses	417,600	389,000
Total expenses	6,926,800	20,101,100
Net income (loss)	($6,484,500)	($17,888,300)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$58,666,300
Recoveries, net of expenses	(19,863,500)
Distributions	(30,586,800)
Monetary assets available for distribution	$8,216,000

Commercial Compensation Casualty Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$3,307,200	$3,347,400
Recoverable from reinsurers	45,528,500	47,747,000
Other assets	28,800	1,800
Total assets	48,864,500	51,096,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	1,696,600	1,582,100
Claims against policies, before distributions	125,811,900	137,233,200
Less distributions to policyholders	(47,982,800)	(49,443,000)
All other claims	11,578,500	11,070,500
Total liabilities	91,104,200	100,442,800
Net assets (deficiency)	($42,239,700)	($49,346,600)

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$65,000	$170,600
Salvage and other recoveries	1,718,800	(762,400)
Total income	1,783,800	(591,800)

Expenses	2008	2009
Loss and claims expenses	30,200	6,477,800
Administrative expenses	110,300	142,500
Total expenses	140,500	6,620,300
Net income (loss)	$1,643,300	($7,212,100)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$6,420,700
Recoveries, net of expenses	46,369,700
Distributions	(49,443,000)
Monetary assets available for distribution	$3,347,400

Western Employers Insurance Company

Conservation Order: **April 2, 1991**
Liquidation Order: **April 19, 1991**

2009 Report

Western Employers Insurance Company ("WEIC") began as a New York-domiciled insurer known as Letherby Insurance Company and was re-domesticated to California in the late 1970's. The company was licensed in 38 states and wrote primarily Workers' Compensation and 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, determine final estate liability and position the Estate for closure by 2011. A significant requirement to meet that objective is to determine how to quantify the remaining long-tail exposure. The Estate will consider seeking a court order to establish a tail-cutting motion at which time claims must be liquidated (finalized) to be considered. The Estate is subject to continued long-term loss development, potential tax exposure, and provided sufficient assets are available at final distribution, the Estate will also consider making an interest payment to approved claimants.

In furtherance of the above mentioned primary objective, on December 17, 2009, the Commissioner filed an application with the court for an order requiring all claimants in the WEIC estate to update their claim. All claimants were served a copy of that application.

On January 12, 2010 the Commissioner again filed and served to all claimants an amended application requiring all claimants to update their claim in the WEIC estate.

On February 2, 2010, the court set a deadline of August 31, 2010 by which all holders of claims, other than workers' compensation claims, which include contingent or undetermined claims, must submit detailed claim updates which set forth the facts regarding the further developments of those claims. The Commissioner has sent a notice to all claimants of record advising of the August 31, 2010 deadline.

Western Employers Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2008 and 2009

Assets	12/31/2008	12/31/2009
Cash and investments	$108,868,100	$124,221,000
Recoverable from reinsurers	18,644,400	18,911,200
Other assets	10,332,000	
Total assets	137,844,500	143,132,200

Liabilities	12/31/2008	12/31/2009
Secured claims and accrued expenses	3,200	21,700
Claims against policies, before distributions	176,653,400	183,305,300
Less distributions to policyholders	(63,029,700)	(62,913,900)
All other claims	6,329,100	6,329,100
Total liabilities	119,956,000	126,742,200
Net assets (deficiency)	$17,888,500	$16,390,000

INCOME AND EXPENSES
For Year Ended December 31, 2008 and 2009

Income	2008	2009
Investment income	$2,203,200	$6,863,000
Salvage and other recoveries	90,500	586,700
Total income	2,293,700	7,449,700

Expenses	2008	2009
Loss and claims expenses	(27,354,800)	8,103,000
Administrative expenses	577,100	825,100
Total expenses	(26,777,700)	8,928,100
Net income (loss)	$29,071,400	($1,478,400)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$74,867,900
Recoveries, net of expenses	112,267,000
Distributions	(62,913,900)
Monetary assets available for distribution	$124,221,000

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. 20

(b) Whether such persons have resumed business or have been liquidated or have been mutualized. 20

(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. 4, 10, 11

(2) Annual operating goals and results. 5-9

(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. 10, 11

(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. .. 13-14

(5) An accounting of total claims by estate. 15

(6) A list of current year and cumulative distributions by class of creditor for each estate. 19

(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. 22-72

(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. 22-72

(2) The status of the conservation and liquidation process. 22-72

(3) Financial statements, including current and cumulative distributions, comparing current calendar year to prior year. 22-72

2009 ANNUAL REPORT

ADMINISTRATION AND LICENSING SERVICES BRANCH

Administration and Licensing Services Branch

The mission of the Administration and Licensing Services Branch (ALSB) is to protect insurance consumers and maintain the integrity of the insurance industry by assisting with the implementation and enforcement of insurance licensing laws, and by providing professional, quality support services to each of the California Department of Insurance's (CDI) programs.

The ALSB consists of the following administrative and licensing divisions:

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

Information Technology Division (ITD)

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

- **Statewide Network Support Bureau** (SNS) 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, usability, and findability wherever CDI has a web presence. The Bureau is responsible for improving the accessibility and usability of CDI's website content and online services while ensuring compliance to state accessibility requirements. Also supported are the CDI's 141 content contributors and content managers responsible for the content in the internet and intranet websites. The Bureau produces videos for CDI, which can be found on the internet and intranet websites.

Ongoing Major Operational Projects:

- **Paperless Workflow Project (PWP)**

  The Commissioner has established an initiative to improve services and reduce waste of State resources by eliminating a large volume of paper based transactions that exist throughout the department. The first phase of the project involves installing a document management system that allows for the electronic routing of documents (workflow), imaging and centralized storage of content for CDI business operations. In September of 2009, EMC Corporation was awarded the vendor solution contract for Phase I. Completed activities included project planning, initiation, and acquisition/installation of all hardware and software required for the project.

- **Online Assistance System for Insurer Submittals (OASIS)**

  OASIS is an electronic document submittal system for applications by insurance companies to operate in California. Ten application types have been completed that includes 33 unique applications with more groups to be completed in the first quarter of 2010. This system collects the appropriate fees electronically for each application type; provides workflow notification to individuals and/or organizations associated with application processing (internally and externally); and provides electronic certification in the event of application approval.

Key IT Accomplishments in 2009:

- **Preferred Provider Organizations Website (PPO)**

  The CDI and the Office of the Patient Advocate (OPA) coordinated the publication of an annual report card on the quality of PPO services. CDI published the PPO Report Card on its public website on November 17, 2009. The CDI website will be updated annually in the last quarter of each calendar year.

- **Network Modernization**

  The Statewide Network Support Bureau migrated all 14 CDI offices to a new wide area network. This new wide area network is called Multi Labeled Protocol Switching (MPLS). This new network improved network speeds and reliability. Additionally, CDI will be saving approximately $100K annually by moving to this technology.

- **Safend**

  The Statewide Network Support Bureau implemented the Safend Data Protection Suite on CDI desktops and laptops to ensure that sensitive information is not transferred outside of the CDI network without the benefit of encryption. Safend enforces an enterprise-wide encryption policy to protect the data stored on systems, so that sensitive data cannot be read by unauthorized users in the case of loss or theft of laptop computers.

- **Websense**

  CDI makes extensive use of sensitive information from individuals and companies for tracking purposes. This sensitive information includes (but is not limited to) social security numbers for Enforcement and Licensing purposes, CDI employee roster information, and insurer's financial assets. CDI has an obligation to its stakeholders, employees, and other government agencies to protect this information from theft, misuse, and improper access.

  The Statewide Network Support Bureau implemented the Websense Data Security Suite on CDI's production network to ensure an audit log is being maintained of how sensitive information is electronically transferred outside of the CDI network. This audit log allows CDI's Information Security Office (ISO) to determine if sensitive information is being transported securely and is not being misused. Staff has been trained in the use of this new technology that will reduce CDI's overall risks as they relate to sensitive information loss. The ISO is currently working on a policy with respect to data loss prevention.

- **Server Virtualization**

  In 2009, the server virtualization effort was completed. The end result was 102 servers were consolidated down to 12 via virtualization software in San Francisco, Los Angeles, and Sacramento. This was done with little downtime and resulted in improved server and application performance. This solution has helped CDI in its green efforts with the reduction of electrical usage and carbon emissions. Additionally, this will reduce CDI's maintenance costs for server hardware.

- **Paperless License**

  ITD provided applicants and licensees with an on-line service to securely log onto the CDI internet web page and locally print their most recent insurance license or certificate in a PDF format.

- **Move Oracle Test and Development Servers to CDI**

  ITD has built and configured new servers on site at CDI to house the Test and Development Oracle Databases. Moving these databases and eliminating the support costs charged by the Office of Technology (OTECH) to CDI has realized estimated cost savings for the 2009-10 fiscal year of $164,000.

- **SERFF on the Internet**

  California Insurance Code mandates that all rate filing applications are available for public viewing. ITD modified CDI's prior rate filing system by enhancing its ability to retrieve CDI non-scanned documents from NAIC in addition to the CDI scanned documents. This new capability provides access to all rate filings on the CDI's internet replacing the need for the hard copy viewing rooms.

- **Paperless Renewal Notices**

  ITD replaced the paper license renewal notice with an automated email renewal notice. The emailed renewal notice provides a web link to CDI's Free Licensing Renewal Service application. This online program guides the licensee, step-by-

step, through the renewal process by asking the same questions that are stated on the traditional mail-in renewal application. The licensee now has the ability to answer the questions online, update contact information (address, email, etc.), and submit a credit card payment (Visa, American Express, MasterCard). This service is provided at no additional charge to the licensee.

- **Department of Child Support Services (DCSS) Weekly Revocation List**

  ITD added functionality that enables CDI to match names of licensees to a weekly revocation list provided by DCSS of parents who are more than four months in arrears on their child support payment. CDI then notifies these parents their license will be suspended in 150 days if CDI does not receive a clearance from the Local Child Support Agency.

- **Licensing Background Bureau (LBB) Case Tracking Changes**

  ITD made enhancements to the LBB case tracking system to allow LBB to increase their efficiency and expand their involvement in the Enterprise Information Portal (EIP) to allow greater management access to information about CDI's operational status and metrics.

- **Enterprise Information Portal (EIP) Enhancement Project**

  ITD has expanded the EIP system incorporating information from other business areas. The reports tab within EIP now offers the monthly "Vacancy Reports" from Human Resources, the "Budget Reports" for all branches, new alerts, and additional key performance indicators for operations. Specifically, the availability of the reports on the web has reduced costs and resources previously associated with the printing and delivery of these reports.

- **Create and Report on Operations Plans for Undercover and Surveillance and for Arrests and Search Warrants**

  ITD provided the ability to capture and develop Undercover and Surveillance Operation Plans and Arrest and Search Warrant Operations Plans in the Fraud Integrated Database (FIDB) system and created reports from this data to be shared with other investigators.

- **Internal Audit Tracking Database**

  ITD has implemented a new tracking database for Internal Audits to replace the mission critical access database. The new system was created using Serena Software to implement new web-based forms and workflow, eliminating the unstable Microsoft Access database.

- **District Attorney Audit Team Database in FIDB**

  ITD provided the DA (District Attorney) auditors the ability to input their statistics and data into a web-based application which interfaces with FIDB allowing information to be captured and shared with other offices.

- **Bi-Monthly Case Review Report**

  A new Supervisor Bi-Monthly Case Review Report was developed in FIDB which replaces the manual process of creating these reports by Fraud supervisors.

- **MySpace Fraud Recruitment Page**

  ITD created a MySpace page to give the Enforcement Branch a presence on this social networking site for the purpose of recruiting new fraud agents and investigators.

- **State-of-the-Art Web Presence: On-going**

  The ITD now produces on-demand videos for its constituents and internal CDI staff, and this offering was added to CDI's public website and internal website. Types of video include Commissioner's Press Conferences, Public Service Announcements, and Public Hearings for the Internet. Videos are presented with open caption versions on its websites. Self-service training and general information videos for internal CDI staff were also added to CDI's internal website. ITD created footage has been seen on local network television stations in northern California.

- **Financial Analysis Division – California Supplements and Annual Renewals Project**

  In addition to the Corporate Affairs Bureau (CAB) project, OASIS was used to facilitate the submittal of financial documents to the Financial Analysis Division (FAD) such as Annual and Quarterly Financial Statements, California Supplements, and Annual Renewals. Up to 1,500 paper filings per quarter will now be eliminated and replaced with electronic filings, which will eliminate an estimated 511,000 sheets of paper yearly that are submitted by industry. This project was completed at the end of December 2009, and industry will use this system for the March 2010 filing period for the annual financial reports.

- **Fusion Center Project**

  The Fusion Center Project was implemented with the software product LexisNexis Accurint for Law Enforcement Plus. This system, designed for law enforcement, provides access to multiple databases with one search while providing powerful analytic tools. In 2009/10, CDI's fraud division stationed top investigators at existing fusion centers such as LA Clear. These investigators will tap into existing fusion centers and gain further access to data that may be relevant in CDI's fraud investigations.

Recognition in 2009

- Government Technology Conference – 2009 Best Solution
- Center for Digital Government – 2009 Best of California

  CDI received the 2009 Best Solution Award at the Government Technology Conference as well as the 2009 Best of California Award for OASIS.

  CDI partnered with Delegata to implement a business transaction and payment system, OASIS, which enables CDI to accept electronic delivery of documents, receive payments by credit card, and in-house online sharing and processing of documents through automated workflows.

The benefits include:

- Reduction in usage of paper for insurance companies and CDI,
- Improved turnaround time of application processing,
- More efficient use of State resources,
- Reduced costs associated with paper handling and storage costs,
- Reduction in liability from missing or lost files, and
- Fewer potential injuries to staff associated with handling heavy files.

Licensing Services Division (LSD)

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 three Bureaus: the Producer Licensing Bureau, the Licensing Background Bureau and the Licensing Compliance and Company Investigations Bureau.

- **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 Eligible Surplus Line Insurers; tests updated computer software systems; and maintains the producer licensing sections of CDI's website.

Key LSD Accomplishments in 2009:

PRODUCER LICENSING BUREAU (PLB)

Producer Licensing Uniformity - PLB successfully implemented new legislation (AB 2044, Chapter 300, Statutes of 2008) which made several changes to the California Insurance Code that took effect on January 1, 2009. Most of the changes made were for the purpose of aligning California's insurance producer licensing laws with other states' producer licensing laws.

Specifically, these changes included reducing the continuing education (CE) requirement for most Fire and Casualty Broker-Agents from 30 hours to 24 hours per license term; allowing Personal Lines Broker-Agents to complete their CE requirement at any time within the license term; redefining the definition of "resident" to include

individuals who do not reside in California but maintain their principal place of business in California; waiving the qualifying examination requirement for licensed agents in other states who move to California; adding some nationally recognized designation programs to the list of programs that meet the standards for prelicensing and CE requirements; providing the Insurance Commissioner the discretion, instead of as a mandate, to charge higher licensing fees to nonresident applicants in those instances when the nonresident applicant's resident state charges a fee greater than California's fee; and finally, establishing a 24-hour CE requirement to be met each license term by California residents who are licensed as either Independent or Public Insurance Adjusters.

Title Marketing Representatives - PLB successfully implemented new legislation (SB 133, Chapter 280, Statutes of 2008) that took effect on January 1, 2009. This law requires individuals who market, offer, solicit, negotiate or sell title insurance to hold a valid Certificate of Registration as a Title Marketing Representative issued by the Insurance Commissioner. The bill also specifies those unlawful activities that are considered to be inducements to any person for the placement or referral of title insurance business.

In addition, PLB successfully implemented regulations (Section 2194.50 et. seq. of the California Code of Regulations) that were needed to fully implement the Certificate of Registration provisions of SB 133.

Use of Senior Designations - PLB successfully implemented new legislation (AB 2150, Chapter 327, Statutes of 2008) that took effect on January 1, 2009. This law prohibits agents and brokers, when selling insurance to seniors, from using a "senior designation" unless the designation has been approved by CDI. A senior designation is defined as any degree, title, credential, certificate, certification, accreditation, or approval, that expresses or implies that a broker or agent possesses expertise, training, competence, honesty, or reliability with regard to advising seniors in particular on finance, insurance, or risk management.

Paperless License - Consistent with the Insurance Commissioner's strategic initiative to have 100 percent paperless interaction with agents, brokers and insurers, effective on July 1, 2009, CDI discontinued the printing and mailing of paper copies of its licenses. Instead, when CDI issues new licenses or renews existing licenses, licensees and applicants receive an email that includes a link to CDI's "Obtain Your License Online" web page. Once at this webpage, licensees and applicants are provided instructions for downloading and printing their license certificate.

As a result of paperless licenses, the annual savings in paper, postage and handling expenses to CDI is estimated at nearly $200,000. This new process also provides increased efficiencies for the insurance industry as it allows licensees to email their license as a pdf attachment, without having to scan it first, to others such as employers, potential employers, insurers, insurance agencies and managing general agents.

Paperless Renewal Notices - For several years, CDI mailed paper renewal notices to its licensees at least 60 days prior to the expiration date of their license. As an alternative to the paper process, in October 2009, CDI began sending email renewal notifications to the individual or organization's email address on record. The notification

includes a link to CDI's "Free Application Online Renewal Service" which allows agents and brokers to renew their license through CDI's website. The notification also includes the license number, license term, license type, and denotes the number of CE hours needed to renew the license.

As a result of paperless renewal notices, the annual savings in paper, postage and handling expenses to CDI is estimated at more than $100,000.

Key LSD Statistics - The chart below compares key workload statistics between calendar years 2008 and 2009.

WORKLOAD	2008	2009	PERCENTAGE CHANGE
License Applications Received	77,698	66,057	- 15%
License Examinations Scheduled	64,700	58,504	- 10%
New Licenses Issued	56,035	48,050	- 14%
Licenses Renewed	104,319	115,424	+ 11%
Appointments and Termination	699,300	662,971	- 5%
Bonds Processed	7,510	7,512	0%
Telephone Calls Handled	123,457	101,356	- 18%

License Information required by the California Insurance Code (CIC) -- AB 720, Chapter 270, Statutes of 2007 added Section 1707.7 to the CIC to require annual statistics on several agent and broker licenses to be included in CDI's annual reports covering the years 2008 through 2012. To meet this mandate, the required statistical information for 2009 is as follows:

(A) During 2009, the total number of applications received for the following license types were as follows:

LICENSE TYPE	NUMBER OF APPLICATIONS
Fire and Casualty Broker-Agent	17,835
Personal Lines Broker-Agent	1,321
Limited Lines Automobile Agent	132
Life Only Agent	2,642
Accident/Health Agent	660
Life and Accident/Health Agent	29,065

(B) During 2009, the total number of licenses issued for the following license types were as follows:

LICENSE TYPE	NUMBER OF NEW LICENSES ISSUED
Fire and Casualty Broker-Agent	12,973
Personal Lines Broker-Agent	961
Limited Lines Automobile Agent	96
Life Only Agent	1,922
Accident/Health Agent	480
Life and Accident/Health Agent	21,142

(C) The total number of licensed Life and Accident/Health Agents on December 31, 2009 was 213,921.

LICENSING BACKGROUND BUREAU (LBB)

During 2009, LBB completed several projects to improve consumer protection, streamline processes and improve customer service.

Development of Uniform Background Review Regulations for the National Association of Insurance Commissioners (NAIC)

During 2009, LBB participated in the NAIC Producer Licensing Working Group to develop national uniform guidelines for the background review of insurance producers and applicants. The background review guidelines set forth uniform standards that can be applied by all state insurance regulators when making licensing decisions. As uniform licensing standards, including fingerprinting requirements, are adopted in all states, the ultimate goal is for each state to defer to the resident state for licensing determinations whenever possible.

Participation in the NAIC Attachments Warehouse

During 2009, LBB on behalf of CDI began participating in the National Insurance Producer Registry's (NIPR) Attachments Warehouse. The Attachments Warehouse is a secure regulatory database which electronically receives, stores and shares licensing documents with other states. Documents may be submitted with applications and renewals of insurance producer licensees through the NIPR, a non-profit affiliate of the NAIC. The documents, such as court papers, most often provide additional information or support to an individual's "yes" response to a background question that is contained in the application.

Licensees may also use the Attachments Warehouse to satisfy their regulatory requirements for notifying and reporting administrative and civil actions to the Insurance

Commissioner pursuant to Section 1729.2 of the California Insurance Code. The Attachment Warehouse saves individuals time and expense since they only have to electronically submit the documents to one central repository instead of sending separate mailings to several states.

Key LBB Statistics - The chart below compares key workload statistics between calendar years 2008 and 2009.

WORKLOAD	2008	2009	PERCENTAGE CHANGE
Background Reviews	3,834	3,678	- 4%
Referred to Legal Branch for Disciplinary Action	251	240	- 6%
Alternative Resolution Program Cases	765	830	+ 8%

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 on-going 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.
- 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.

Alternative Resolution Program

LBB handles many of its cases under CDI's Alternative Resolution Program, which consists of having LBB analysts, rather than attorneys, prepare the necessary legal documents to impose discipline. The Alternative Resolution Program saves thousands of hours of valuable attorney time and enables CDI attorneys to focus their attention to more serious types of cases. The Alternative Resolution Program also helps expedite the licensing process for some applicants.

LICENSING COMPLIANCE AND COMPANY INVESTIGATIONS BUREAU (LCB)

The Licensing Compliance and Company Investigations Bureau was originally created in 2006 and underwent a significant structural reorganization that was finalized in November 2009.

LCB consists of four units: the Licensing Compliance Unit, the Company Investigations Unit, the Surplus Line Filing Unit, and the Licensing Website and Online Services Unit.

Citation Program - LCB successfully implemented new legislation (AB 2044, Chapter 300, Statutes of 2008) which made changes to the California Insurance Code that took effect on January 1, 2009. The new legislation repealed Sections 1745 and 1746, which contained a former "reprimand" program, and added Section 1746, establishing a "citation and fine" program to enforce minor violations of the California Insurance Code committed by insurance producers and applicants.

Reorganization - The primary impetus driving the reorganization came from recommendations made from the 2008 top-down review of CDI. The report included recommendations to shift two Associate Management Auditor positions from the Ethics and Operational Compliance Office (EOCO) to PLB and also to reallocate two positions from LCB's Business Process Reengineering Unit to EOCO. Another factor contributing to the reorganization was to more equitably align the workload and staffing levels for LBB and LCB.

As a result of the transfer of the business process reengineering function to EOCO, LCB's Business Process Reengineering Unit was disbanded. Of the three analysts reporting to that unit, one analyst continued to perform her same duties and formed a one person unit entitled the "Licensing Website and Online Services Unit." The other two LCB analysts were retrained to perform licensing background reviews and became part of a new four-person unit in LCB, entitled "Company Investigations Unit". To form this unit, two analysts were moved from LBB to LCB. These new units are explained in more detail below.

Under the new structure, LCB's Company Investigations Unit assumes the lead role for background reviews of officers and directors of insurance companies. Meanwhile, LBB continues as the lead for background reviews of insurance producer license applicants. The array of other background review cases is handled by both bureaus.

Company Investigations Unit

The Company Investigations Unit (CIU) performs investigative analysis and background reviews of officers and directors of insurance companies transacting or seeking to transact business in California. Those reviewed include current admitted insurers, surplus line insurers, and companies applying for certificates of authority, mergers and acquisitions. CIU also works closely with LBB to conduct the full array of investigative analysis and licensing background reviews on individual licensees and those applying for licensure.

Key LCB Statistics - The chart below shows the key workload statistics for calendar year 2009.

WORKLOAD	2009*
Background Reviews Completed	760
Company Investigation Unit Cases Completed	114
Referred to Legal Branch for Disciplinary Action	109
Alternative Resolution Program Cases	122

* The chart above provides workload statistics for cases worked by CIU staff in 2009. This is a significant part of LCB's workload and will be reflected more in years to come. There is no comparative data since LCB underwent a major reorganization in 2009 and this is the first year to monitor such data.

Licensing Compliance Unit

The Licensing Compliance Unit is responsible for reviewing minor violations of the California Insurance Code committed by California-licensed insurance producers. Suspected minor violations are referred to the Unit by CDI's Investigation Division (Complaint Intake Unit).

These referrals include the use of unapproved fictitious names, individuals transacting insurance with an invalid license or without a license, improper or misleading advertising, and other minor violations of the California Insurance Code. The Unit's primary goal is to bring those in violation into compliance. In cases where the subject will not cooperate, or in case of repeated non-compliance, the Unit will refer the case back to the Investigation Division for further review or initiate formal legal action through the Alternative Resolution program.

The chart below shows the licensing compliance cases completed in calendar years 2008 and 2009.

CASES	2008	2009	PERCENT CHANGE
Issued Warning Letters- Brought into Compliance	94	64	-32%
No Violation Found	35	33	-6%
Referred to Other CDI Entities	27	20	-26%
Referred to Legal Branch	10	5	-50%

Licensing Website and Online Services Unit

The Licensing Website and Online Services Unit is a one-person unit that was formed as a result of LCB's reorganization in November 2009. This unit is responsible for providing website and online service support for the entire LSD. This unit is integral to the efficiency and effectiveness of the division's operations and the ability of LSD to maintain and provide quality online licensing services to consumers and licensees.

Some of the primary functions include monitoring and maintaining the content on the licensing portions of the CDI's public website and intranet, testing and validation of new online services, and maintaining the Call Center Interactive Voice Response system. This unit works closely with CDI's Information Technology Division to test and validate new and updated computer software systems implemented in LSD prior to full implementation. Currently, the unit is heavily involved in the ongoing testing, validation and launch of a new web-based browser licensing system that will replace the current client-server system as the primary insurance licensing database. The conversion is expected to occur by 2011.

Surplus Line Filing Unit

The Surplus Line Filing Unit assists in processing the applications of non-admitted insurers applying to be added to the Department's List of Eligible Surplus Lines Insurers (LESLI). This unit coordinates with the CDI's Legal Branch and Financial Analysis Divisions and the Surplus Line Association of California in licensing and regulating the state's surplus line insurers.

Human Resources Management Division (HRMD)

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

- **The Classification and Pay Unit** processes varied and complex personnel management issues including analyzing and classifying positions; gathering and evaluating pay data; conducting classification and/or pay surveys; preparing formal memorandums or reports on personnel matters; participating in the presentation of personnel matters before the State Personnel Board (SPB), the Department of Personnel Administration (DPA), or other official bodies; reviewing proposed personnel actions for conformity with regulations, classification and pay standards, and sound personnel practices.

- **The Exams, Recruitment, Selection and Training Unit** administers all hiring for the Department, utilizing the Civil Service Exam process; administers certification and eligibility lists; oversees recruitment efforts; develops and delivers in-house training using instructor led-training and intranet based training videos; coordinates training for Department employees; facilitates the Department's annual award and recognition programs; and administers Workforce Succession Planning for the Department.

- **The Health & 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 & Safety Unit acts as coordinators for the Family and Medical Leave Act (FMLA), Catastrophic Leave (CAT), Americans with Disabilities Act (ADA), Reasonable Accommodation Policy (RA), Return-to-Work, Drug-Free Workplace, the Workers' Compensation Program, the Health and Wellness Program, and administers ergonomic information for CDI employees.
- **The Labor Relations Unit** facilitates cooperative and productive labor relations between the Department, 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 departmental policies, and grievance responses.
- **The Personnel Transactions Unit** independently evaluates and processes various complex and sensitive personnel transactions in compliance with applicable bargaining unit agreements, contract/MOU language, departmental policies and procedures, DPA, SPB, and State Controller's Office (SCO) laws and rules. Maintains leave balances; tracks attendance; processes all health, dental, vision benefits; administers position control; and processes all payrolls.
- **The Technical Resources Unit (TRU)** provides technical expertise, training, guidance, assistance, and support to employees, supervisors, and managers regarding administrative personnel matters; provides advice and assistance to the HRMD staff on such topics as, recruitment, hiring, classification and compensation, employee discipline, and employee relation issues, to ensure consistent and accurate answers. The TRU also issues and disseminates the HRMD policies, procedures, and personnel related documents. The TRU develops methods, processes and procedures regarding complex and diverse personnel practices designed to obtain consistency within HRMD and the CDI, develops desk manuals, guidelines, memorandums, and other forms of written communication and job aids to assist HRMD staff.

Key HRMD Accomplishments in 2009:

Intranet Redesign project for HRMD

- HRMD homepage was loaded onto the intranet and is constantly in the process of change as we review our practices. The webpage contains the various discipline pages, related links, and updated HRM forms for on-line access. HRMD continues to review every item on the old intranet site, as it is moved to the new intranet site. A review in April 2008 showed that HRMD had approximately 600 forms. Most were duplicates or revisions. Our estimated form count, in reality, should be approximately 125. As of December 2009, HRMD has created and revised approximately 85 forms. We now have 26 remaining forms that need to be reformatted.

Developed and Delivered a Robust Training Program Model for CDI Supervisors and Managers

- Implemented the first-level of the five-level leadership academies April 1, 2009. Conducted four courses: Administrative Organizational and Procedural Skills, Effective Communication and Interpersonal Skills, Innovative Leadership, and Coaching and Skill Transfer. Due to budget cuts, the program was cancelled in October 2009. The Coaching and Skill Transfer course was conducted once before the program was cancelled.

Developed In-House Supervisory/Managerial Training Program

- In lieu of using an outside vendor to provide training for supervisors and managers, an in-house supervisory training program was developed by CDI subject matter experts.
    - Developed a Fair and Equitable Employee Treatment course covering Labor Relations and Health and Safety Procedures.
    - Courses to be developed include Hiring and Retention, Feedback and Evaluation, and CDI Business Procedures.

Developed On-Line New / Transfer Employee Information Page

- Drafted two intranet pages, with information for new and transfer employees, and submitted for review. The anticipated release of these pages is May 1, 2010. The proposed on-line information will be efficient in several ways:
    - Will alleviate the postage charges of sending New / Transfer Employee packages to new and transfer CDI employees.
    - Will reduce the paper used to reproduce each form, policy, org chart, mission statement, etc. to be sent to the new / transfer employees to CDI.
    - Will eliminate the removal of hard copies of information when there are revisions.
    - Will eliminate almost all of the man hours HRMD uses to copy, package and mail the new / transfer employee packages to new CDI staff.
    - On-line information will also be more accurate as when items are revised CDI website will be also. This will negate confusion and requests to replace contents.

Paperless Workflow Project

- Act as lead for the Training Team in the Department's Paperless Workflow Project.
    - Determine appropriate training methodology to be used for each business process of the project.
    - Coordinate the number and level of training classes that will be required, determine who the CDI trainers will be and ensure that training courses meet employee needs using survey-based assessments.

Streamline the Training Registration System

- This project will identify processes/procedures that will improve or eliminate redundancy in registering employees for training.
    - Flowcharts of the training plan and registration process were completed and provided to ITD.
    - The Training Expenditure Request (TER) process was selected as a paperless workflow project by ITD.
    - Due to fiscal constraints, the TER process of the Paperless Workflow Project was postponed.

Workforce Succession Plan

- The strategic plan will ensure that CDI has an adequate number of CDI employees – from the next generation who are prepared to carry out management practices. This includes the following:
    - Collecting and analyzing data of employees expected to retire within the next 10 years;
    - Identifying classifications to be targeted (by Branch, Occupational groupings), and;
    - Developing framework for a department workforce succession plan

- Financial Surveillance Branch was selected to pilot the first plan.
    - May 21, 2009 kickoff meeting with committee members held.
    - Facilitated committee to identify 21 “Key Technical Responsibilities” for the management classifications.
    - Mapped 6 of the 21 key leadership responsibilities to tasks, knowledge, skills, abilities, personal characteristics and performance criteria.

- Partnered with Business Process Re-engineering Unit to develop a program to implement Workforce Succession Planning for the rest of the department.
    - Deputies were notified of the importance of Workforce Succession Planning.
    - Began working with critical class areas to get an understanding of their work functions, challenges and what they anticipate might be changing in the future. This involved face-to-face meetings and conference calls to meet with those in the critical classes.

Developed onsite Softskills training for CDI Employees

- Developed and delivered four pilot classes for ALSB and all Sacramento employees:
    - Employee Motivation and Morale
    - Effective Communication and Interpersonal Skills
    - Cross-cultural Communication
    - Understanding and Working with Generational Differences
    - These four classes are also available as intranet based training videos in order to accommodate employees outside of the Sacramento area.

Conduct Job Analysis Reports

- SPB requires (before delegation is approved by departmental staff to conduct examinations) the completion of a job analysis report. These reports not only provide for test validation, but 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 our processes and decisions, should they be challenged in court. Nine Job Analysis Reports completed in 2009 as follows:
    - Associate Budget Analyst
    - Associate Insurance Investigator
    - Associate Insurance Rate Analyst
    - Associate Life Actuary
    - Bureau Chief, Enforcement Branch
    - Executive Assistant
    - Senior Insurance Examiner (Specialist)
    - Senior Insurance Examiner (Supervisor)
    - Supervising Casualty Actuary

Reduce CDI Workers Compensation Costs

- Health & Safety Unit Analysts have closed 37 workers' compensation cases in 2009, an increase of approximately 14% over 2008. There are currently eight cases that do not require management; however, the cases remain open on our workers' compensation log because the permanent stationary incumbents require on-going medical treatments for the foreseeable future, or the settlement of their permanent disability included weekly life pension amounts. These are called "maintenance" cases.

  In addition, the Health and Safety Unit is conducting a major study of different workers' compensation program handling - agencies that have a policy with the State Compensation Insurance Fund; agencies that are self-insured with the State Compensation Insurance Fund providing case management; and agencies that are self-insured and manage their own cases including medical referral and bill payment. This complex study will probably not be completed until mid 2011.

Nepotism Policy and Procedures

- The Nepotism Policy and Procedure was drafted to replace the Department of Insurance Manual Section 7.8 (S) Nepotism. Nepotism is defined as employees using their organizational position, power, or influence to aid or hinder other persons in securing employment, promotions, appointments, project assignments, or other employment benefits solely because of a familial or personal relationship.

Memo Personnel

- TRU reviewed all Memo Personnel notices that were sent from the Memo Personnel with an inception date prior to December 11, 2007. Obsolete Memo Personnel notices were removed from the intranet and current vital Memo

Personnel notices were uploaded. Memo Personnel notices will be added and deleted as required. In the year 2009, HR issued approximately 300 Memo Personnel notices. Memo Personnel now has a distribution list of 29 groups of various employee groups. In 2009, Memo Personnel issued notices regarding voting, blood drives, furloughs, calendars, exams, Catastrophic Leave participants, and more.

Blood Drives

- The Health & Safety Unit organized a total of five blood drives at the Sacramento Headquarters office for the year 2009.

Did You Know Newsletter

- Added a "Did You Know" (DYK) section to the HRMD website. The monthly issued newsletter provided pertinent HR-related information and included Green articles, COIN articles, and Cyber Security Tips to all employees. The September 1, 2009 issue was the final issue. The DYK was replaced by the inclusive CDI Newsletter.

HRMD Responsibility and Discipline Function Chart

- The HRMD Responsibility and Discipline Functions Charts were created, released and added to the intranet to assist employees in identifying discipline responsibilities.

HRMD TRU Facts

- The TRU Facts for CDI HRMD staff is now complete and will be updated as needed. TRU Facts provides law, rule, government codes, and examples to the more complex HR quandaries to HR staff. The CDI TRU Facts has a total of 18 sections at this point. TRU facts will be released to in-house HRMD staff only during the early part of 2010.

Personnel Specialists Training

- The HRMD Personnel Specialists (PS) have received training in all courses made available to them. The only training courses the PS staff has yet to receive are Garnishment and Advanced Salary Determination. These two classes were not offered in 2009.

Financial Management Division (FMD)

The Financial Management Division consists of three bureaus: the Accounting Services Bureau, the Budget and Revenue Management Bureau, and the Business Management Bureau.

- **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 $2.11 billion in tax revenue was collected for Fiscal Year 2008-09 to support the State's General Fund. The ASB maintains

centralized records of the CDI's appropriations, financial activities, and cash flow to ensure effective management of the 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 Governor's Budget; develops annual budget allocation for all program clients; develops various hourly rates for cost recovery; and monitors expenditures and revenue collection during the fiscal year.

  The Administrative Systems Unit 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 department-wide administrative and management services in the areas of Purchasing, Contracting, Facilities, Records, Forms, Equipment, Publications and Fleet management. BMB provides mail and supply services at all three headquarters offices. BMB also provides employees services with photo identification and security, transportation management, and disaster management planning.

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 the CDI are monthly, quarterly, or annually depending upon the tax liability of each insurer/surplus line broker.

Pursuant to California Insurance Code Section 1775.1, every surplus line broker whose annual tax for the preceding calendar year was Five Thousand Dollars ($5,000) or more shall make monthly installment payments on account of the annual tax on business done during the calendar year.

Pursuant to California Revenue and Taxation Code Section 12251, insurers transacting insurance in this state and whose annual tax for the preceding calendar year was Five Thousand Dollars ($5,000) or more shall make quarterly prepayments of the annual tax for the current calendar year.

For the tax year 2008, the Accounting Services Bureau processed a total of 5,197 tax returns as follows:

INSURANCE TYPE	NUMBER OF ANNUAL TAX RETURNS	TAX RATE	LAW REFERENCE
Surplus Line	3,300	3%	California Insurance Code 1775.5
Property & Casualty	886	2.35%	California Revenue & Taxation Code 12202
Ocean Marine	514	5%	California Revenue & Taxation Code 12101
Life	451	2.35% or 0.5%	California Revenue & Taxation Code 12202
Title	23	2.35%	California Revenue & Taxation Code 12202
Home	13	2.35%	California Revenue & Taxation Code 12202
Total	**5,197**		

CALIFORNIA DEPARTMENT OF INSURANCE

A 5-YEAR SUMMARY OF PREMIUM AND SURPLUS LINES

TAXES COLLECTED BY THE DEPARTMENT OF INSURANCE
FOR THE STATE OF CALIFORNIA

Fiscal Year Ending June 30	
2004	$2,056,524,000
2005	$2,124,097,000
2006	$2,167,242,000
2007	$2,170,752,000
2008	$2,109,639,000*

* Collection as of March 31, 2010

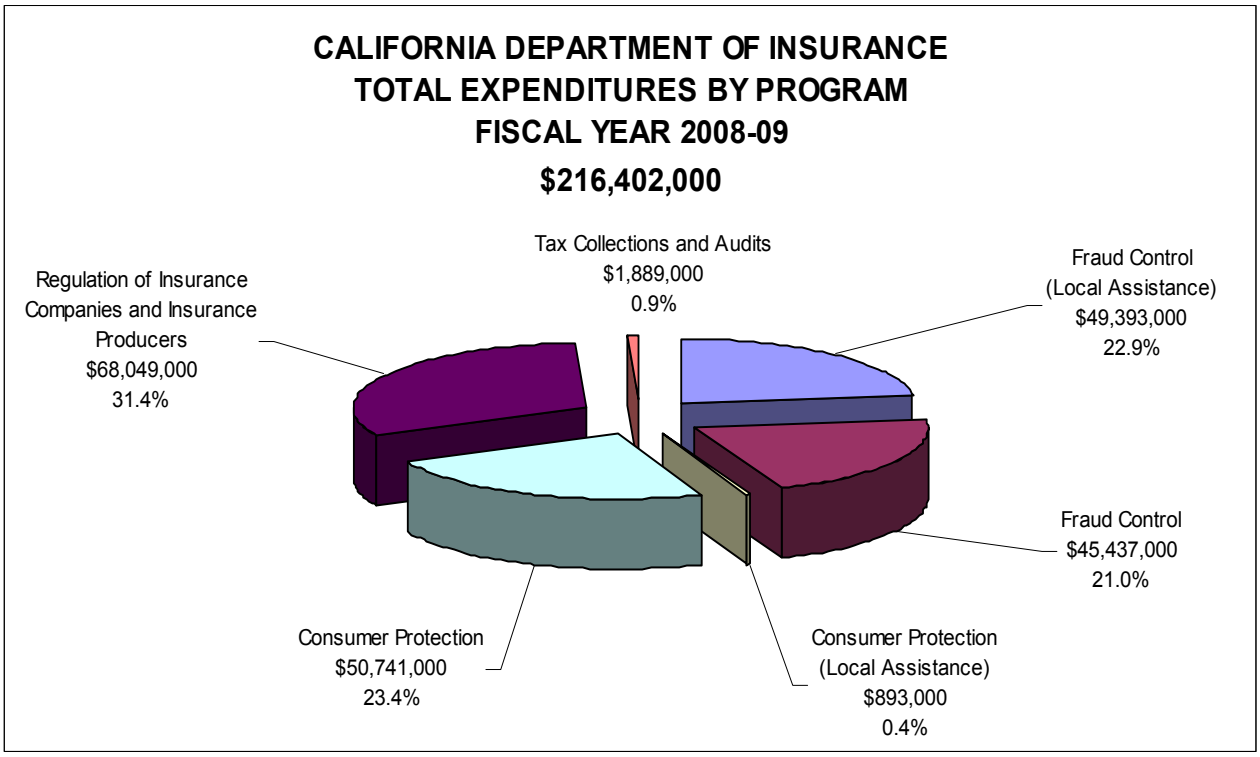
CDI BUDGET—For FY 2008-09, the CDI's budget consisted of the following four programs:

- **Regulation of Insurance Companies and Insurance Producers (Program 10)** - $68,049,000 of the FY 2008-09 budget was expended by this program which aims 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 producers.

- **Consumer Protection (Program 12)** - $50,741,000 was spent for state operations and $893,000 for local assistance in FY 2008-09. The program provides direct service to California consumers by protecting insurance policy holders 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)** - $45,437,000 was spent for state operations and $49,393,000 for local assistance in FY 2008-09. The program protects 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 local assistance, as an example, district attorneys receive funding to implement the Organized Automobile Fraud Activity Interdiction program.

- **Tax Collections and Audits (Program 30)** - $1,889,000 was spent in FY 2008-09 performing tax collection, accounting and tax audits of insurance companies and surplus line brokers. This program collects approximately $2.1 billion for the State's General Fund.



The pie graph above shows the Department of Insurance total expenditure by program for fiscal year 2008-2009 as follows:

Regulation of Insurance Companies and Insurance Producer	$68,049,000 (31.4%)
Consumer Protection	$50,741,000 (23.4%)

Fraud Control (Local Assistance)	$49,393,000 (22.9%)
Fraud Control	$45,437,000 (21.0%)
Tax Collections and Audits	$1,889,000 (00.9%)
Consumer Protection (Local Assistance)	$893,000 (00.4%)
Total	$216,402,000

CDI REVENUES

In 2008-09, the CDI generated $216 million in revenue from fees and licenses and various assessments paid by insurers, agents, and other licensees. Insurance Fund receipts are generally received from the insurance companies and producers that the CDI services and regulates. Both insurers and producers pay license, filing, and other fees. Insurance companies pay special assessments for Proposition 103, Workers' Compensation Fraud, Auto Fraud and General Fraud. 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	% TO TOTAL
License Fees and Penalties	$36,764,000	17.0%
Fees, Examination	$21,739,000	10.1%
Fees, Proposition 103	$26,421,000	12.2%
Fees, General	$21,429,000	9.9%
Fraud Assessment	$96,052,000	44.4%
Consumer Services ($0.30)	$8,772,000	4.1%
Life & Annuity	$1,736,000	0.8%
Miscellaneous	$3,097,000	1.5%
TOTAL, INSURANCE FUND REVENUE	$216,010,000	100.0%

- **License Fees and Penalties** - This is revenue collected to cover the cost associated with the licensing and regulation of persons engaged in the business of insurance in California.

- **Examination Fees** - This is revenue 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 insurance code.

- **Proposition 103** - This is a voter-approved initiative that requires the CDI to review and approve certain insurance rates. An annual assessment is levied to recover the actual costs incurred by the CDI in administering the provisions of Proposition 103.

- **Filing and Other Fees, General** - These fees cover the costs associated with processing and maintaining Action Notices, Policy Approvals, Insurer Certifications, Annual Statements and Worker's Compensation Rate Filings.

- **Fraud Assessment** - This revenue is derived from the following assessments:
  1. Worker's Compensation - The Fraud Assessment Commission determines the allocation of revenue. The Department of Industrial Relations collects the assessment from insurers and self-insured employers.
  2. Fraud Auto - An annual fee of $1.50 for each vehicle insured by an insurer. Part of the assessment collected is distributed to the California Highway Patrol and to county District Attorneys.
  3. Fraud General - An annual fee of $5,100 to each insurer doing business in the state.
  4. 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 CDI and improve consumer functions related to automobile insurance. Part of the fee (up to $0.05) is 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.

CDI DISBURSEMENTS

The chart below illustrates the CDI's disbursements by category for FY 2008-09:

CATEGORY	DISBURSEMENT
Personal Services	$110,510,000
Operating Expenses and Equipment	$55,607,000
Local Assistance	$50,285,000
TOTAL DISTRIBUTED	**$216,402,000**

- **Personal Services** - These are payments made for services performed by CDI staff to implement government programs. This includes salaries and wages, and staff benefits.

- **Operating Expenses and Equipment (OE&E)** - 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., counties, cities, municipalities, special districts, etc.) in support of the CDI's programs.

2009 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.

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 the efficiency and facilitate communication between the Rate Filing Bureaus and insurers. The percentage of filings received via SERFF continues to increase each year. During 2009, the percentage of total filings received through SERFF increased to eighty four percent (84%), up from seventy nine percent (79%) in 2008.

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 2009, four hundred eighty nine (489) 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 2009, one hundred forty three (143) title insurance rate filings were reviewed. The RRB also collaborated with other Department branches in 2008 in the development of a revised Title Stat Plan that for data collection purposes is expected to be implemented on January 1, 2011.

Types of Filings Received During 2009	2009	2008
Private Passenger Automobile	518	753
Homeowners	217	289
Other Personal Lines Products	396	362
Title	143	88
Workers' Compensation	489	536
Medical Malpractice	39	51
Other Commercial Lines Products	4983	6268
Total	**6785**	**8347**

Rate Specialist Bureau (RSB)

The Rate Specialist Bureau (RSB) provides technical 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 the projects and duties handled in 2009.

1. During 2009, RSB worked with the Title Insurance Working Group in developing title insurance regulations. RSB took on the major responsibility of revising the Statistical Plan. The regulations and the statistical plan were adopted by the Commissioner and approved by the Office of Administrative Law in 2009.
2. RSB continued to assist 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-to-Earned premiums Ratios; Industry Rates-of-Return; 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.

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

3. RSB conducted the Survey of Marketing System Information to collect data in order to update the calculation of efficiency standards. It originally started as a special project in 2008, but has been made into an annual project.
4. RSB compiled: California Market Share Reports for Property & Casualty insurance, for Life & Annuity insurance, for Title insurance, and for Home Warranty; a 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.
5. RSB 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. RSB promulgated the Proposition 103 Administration Fees for property & casualty companies, and the workers' compensation filing fee charges for the Accounting Division.
7. RSB 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 the loss and experience data of credit property and credit unemployment insurance pursuant to (CIC §779.36, amended by Statutes of 1999, Chapter 413, Section 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. Consequently, the Legal/Medical Liability results included in this report are for 2008.
8. RSB 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. RSB 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. RSB 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 §11555.2: Malpractice Insurance – Dental, Medical, and Legal

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 on the following 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 2009.

Per CIC §674.5 & §674.6:

PRIOR WITHDRAWAL & CEASE-WRITING NOTICES RECEIVED BY THE INSURANCE COMMISSIONER DURING 2009

NAIC #	Company Name	Group Name	Request Date	Effective Date	Proposed Action by Company
10920	Alliance United Insurance Company	Alliance United Ins Company	1/27/2009		Temporarily suspend the sales of the GAP program (GAP Insurance - Private Passenger Automobile)
10799	Geovera Insurance Company	Geovera Holdings Inc Group	2/27/2009	5/1/2009	Discontinue the Dwelling Fire Program in CA.
32620	National Interstate Insurance Company	American Financial Group	3/23/2009	6/1/2009	Withdrawal of Personal Watercraft.
43699	American Federation Insurance Company	Zurich Ins Group	4/16/2009	7/1/2009	Convert policies from American Federation Ins Co to Foremost Ins Co.
33855	Lincoln General Insurance Company	Kingsway Group	5/12/2009	8/1/2009	Complete withdrawal from its Homeowners line of business in CA.
11177	First American Financial Insurance Company	IFG Co	5/19/2009	12/1/2009	Cease offering Commercial Liability insurance.
42048	Diamond State Insurance Company	United National Group	7/17/2009		Non-renew a block of property and casualty business written under their Health Club Program.
10561	Catholic Relief Insurance Company Of America		9/18/2009		Withdraw from doing business in the State of California effective date 9/18/09.
24767	St. Paul Fire And Marine Insurance Company	Travelers Group	10/5/2009	1/1/2010	Discontinue writing aviation insurance.
37931	American Farmers & Ranchers Insurance Company	American Farmers & Ranchers Group	10/8/2009	12/7/2009	Non-renew and withdraw its commercial Risk Manager program.

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). The following is aggregate summary of the data submitted for calendar years 2006 and 2007.

For calendar year 2008, 25 property-casualty companies/groups admitted to do business in California submitted data under CIC §1864 requirements. Of the 25 insurers, 16 insurers submitted data for FDC Homes insured either on a separate liability policy or as an endorsement to the homeowners' policy. Eighteen (18) insurers submitted data for licensed CC Centers.

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

Of the 16 companies/groups reporting data for FDC Homes in 2008, 6 insurers had direct written premium exceeding $100,000. These 6 insurers provided coverage for 12,580 FDC Home providers, approximately 98.5% of all the FDC business insured. Of these 16 insurers: 6 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 5 carriers insured over 450 providers each.

INSURERS REPORTING DATA FOR FAMILY DAY CARE HOMES: PART 1

Range: Insured Count	# of Companies Writing		# of FDC Homes (Providers) Insured			
	2007	2008	2007	% of Total	2008	% of Total
From 0 - 10 providers	6	6	21	0.16%	15	0.12%
From 11 - 100 providers	4	4	191	1.44%	173	1.35%
From 100 - 450 providers	1	1	191	1.44%	331	2.59%
Over 450 providers	6	5	12,904	96.97%	12,249	95.94%
TOTAL	17	16	13,307	100.00%	12,768	100.00%

INSURERS REPORTING DATA FOR FAMILY DAY CARE HOMES: PART 2

	# of Companies Writing		# of FDC Homes (Providers) Insured			
	Calendar Year: 2007	Calendar Year: 2008	Calendar Year: 2007		Calendar Year: 2008	
Small FDC Homes (1-6 children)	14	14	9,794	73.60%	9,047	70.86%
Large FDC Homes (7-12 children)	9	3	3,513	26.40%	3,721	29.14%
Total Insurers Providing Coverage	17	16	13,307	100.00%	12,768	100.00%

Of the 16 insurers that wrote child care liability insurance for FDC Homes in 2008, 14 insurers wrote coverage for Small FDC Homes (licensed for 1 to 6 children) and 8 wrote coverage for Large FDC Homes (licensed for 7 to 12 children). Of the 14 Small FDC Home insurers, 4 insurers had direct written premium exceeding $100,000. They insured approximately 95.4% of all Small FDC Homes. Of the 8 Large FDC Home insurers, 3 insurers had direct written premium exceeding $100,000. They insured about 99.0% of all Large FDC Homes.

Policy Writing Activity: Child Care Centers (CC Centers)

Of the 18 companies/groups which submitted data for licensed Child Care Centers in 2008, 9 insurers had direct written premium exceeding $100,000. These 9 carriers insured approximately 99.0% of the CC Center business.

Of the 18 insurers submitting data: 7 carriers insured from 0 to 10 CC Centers each; 2 carriers insured between 11 and 50 CC Centers; 1 carrier insured between 51 and 200 CC Centers; and 8 insurers wrote more than 200 CC Centers in 2008.

INSURERS REPORTING DATA FOR CHILD CARE CENTERS

Range: Insured Count	# of Companies Writing		# of Child Care Centers Insured			
	2007	2008	2007		2008	
From 0 - 10	4	7	11	0.33%	22	0.57%
From 11 - 50	3	2	41	1.22%	24	0.62%
From 51 - 200	2	1	391	11.65%	197	5.11%
From 201+ providers	7	8	2,913	86.80%	3,614	93.70%
TOTAL	16	18	3,356	100.00%	3,857	100.00%

INSURERS' ACTIVITY IN 2008

From the information provided for calendar year 2008, there was a slight increase in the overall total of child care providers insured, for both FDC Homes and CC Centers. 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 2007	Calendar Year 2008	Calendar Year 2007	Calendar Year 2008
# of Insurers Reporting Data	17	16	16	18
# of Policies In-Force at Beginning of Year	12,076	12,179	2,941	3,120
# of Policies In-Force at End of Year	12,252	11,951	2,770	3,316
Change in # Policies In-Force at End of Year	1.46%	-1.87%	-5.81%	6.28%
# Insurers w/ No Policies In-Force at End of Year	0	1	2	1

EXHIBIT II: Breakdown of Form and Coverage Types Written During 2007 and 2008

FAMILY DAY CARE HOMES (Licensed for 1-6 children or 7-12 children)

17 insurers reported data for calendar year 2007 / 16 insurers reported data for 2008

Family Day Care Homes

FORM TYPE:	# of Companies Writing	
	2007	2008
o Occu rrence Policy	16	15
o Claim s-Made Policy	1	1
o Both Occurrence & Claims-Made Policy	0	0
o Not Specified	0	0

COVERAGE/LIMITS:	# of Companies Writing	
	2007	2008
o 100/300 limit, OL&T	0	0
o 300 CSL, OL&T	0	0
o Endorsement to Homeowners Policy	6	7
o Up to $1 Mil+ CSL	5	4
o Various CSL Limits (from 100K to 500K)	0	0
o Various: up to 1Mil / All Other +	3	4
o Various - Not Specified	3	1

CHILD CARE CENTERS (Licensed for 13+ children)

16 insurers reported data for calendar year 2007 / 18 insurers reported data for 2008

Child Care Centers

FORM TYPE:	# of Companies Writing	
	2007	2008
o Occu rrence Policy	15	15
o Claim s-Made Policy	1	1
o Both Occurrence & Claims-Made	0	2

COVERAGE/LIMITS:	# of Companies Writing	
	2007	2008
o 100/300 limit, OL&T	1	1
o 300 CSL, OL&T	1	1
o Various Limits (below $1 Mil)	1	1
o Various Limits (up to & above $1 Mil+ CSL	6	7
o Various ($1M/$1M; $1M/All Other; higher limits)	5	6
o Various - Not Specified	2	2

EXHIBIT III: Insurers Reporting Child Care Data for Calendar Year 2007 vs. 2008 per CIC §1864

INSURERS REPORTING:	CALENDAR YEAR 2007		CALENDAR YEAR 2008		Policy Type
	Family DC Homes	Child Care Centers	Family DC Homes	Child Care Centers	
Allstate Insurance Group	X		X		OC
Armed Forces Insurance Exchange	X		X		OC
Brotherhood Mutual Insurance Co.				X	OC
California Casualty Insurance Cos.	X		X		OC
Church Mutual Insurance Co.	X	X	X	X	OC
Diamond State Insurance Co.				X	CL/OC
Farmers Insurance Group	X		X		OC
Grange Insurance Group	X		X		OC
Great American Insurance Group		X		X	OC
Great Divide Insurance Co.	X	X		X	OC
GuideOne Insurance Group	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	OC
Philadelphia Indemnity Insurance	X	X	X	X	CL/OC
Riverport Insurance Co. of CA	X	X	X	X	OC
SAFECO Insurance Companies	X	X	X	X	CL
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
Zurich U.S. Ins. Group		X		X	OC
# of Insurers Submitting Data	17	16	16	18	

Total # of Insurers Submitting Data for 2007: 23

Total # of Insurers Submitting Data for 2008: 25

EXHIBIT IV

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 **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
# Insurers Reporting Data	17	16	16	18	23	25
1) Premiums Earned	$4,223,315	$3,807,899	$4,806,986	$4,711,639	$9,030,301	$8,519,538
2) Premiums Written	$4,297,973	$3,919,740	$5,688,835	$5,600,080	$9,986,808	$9,519,820

Number of Claims:

	FAMILY DAY CARE HOMES Licensed for 1-6 or 7-12 Children		CHILD CARE CENTERS Licensed: 13 or more Children		COMBINED DATA FDC Homes & C C Centers	
	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
3) Outstanding at Beginning of Year	38	66	73	91	111	157
4) New - During Reporting Period	136	53	192	230	328	283
5) Closed During Reporting Period	110	48	191	238	301	286
6) Outstanding at End of Year	64	71	74	83	138	154
7) Total Losses Incurred	$607,952	$1,764,271	$2,806,716	($194,846)	$3,414,668	$1,569,425
8) Loss Ratio (7)/(1)	14.40%	46.33%	58.39%	-4.14%	37.81%	18.42%
9) Loss Adjustment Expenses (LAE)	$470,772	$576,714	$347,988	$602,338	$818,760	$1,179,052
10) Total Losses Incurred + LAE	$1,078,724	$2,340,985	$3,154,704	$407,492	$4,233,428	$2,748,477
11) Loss & LAE Ratio (10)/(1)	25.54%	61.48%	65.63%	8.65%	46.88%	32.26%

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 **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
12) In-Force at Beginning of Year	12,076	12,179	2,941	3,120	15,017	15,299
13) Written During the Year	4,114	4,190	623	573	4,737	4,763
14) Cancelled During the Year	614	934	275	292	889	1,226
15) NonRenewed During the Year	3,324	3,484	519	85	3,843	3,569
16) In-Force at End of Year	12,252	11,951	2,770	3,316	15,022	15,267

EXHIBIT IV (continued)

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

17) Allocation of Expenses:

	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 **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
a. Commissions	$818,063	$785,743	$751,829	$713,477	$1,569,892	$1,499,220
b. Other Acquisition Costs	$220,217	$241,796	$286,659	$325,633	$506,876	$567,429
c. General Expenses	$196,811	$217,750	$259,613	$264,278	$456,424	$482,027
d. Taxes, Licenses, Fees	$108,094	$106,596	$111,910	$108,086	$220,004	$214,681
18) Total Underwriting Expenses	$1,343,185	$1,351,884	$1,410,011	$1,411,473	$2,753,196	$2,763,357
Total Expense Ratio [(18)/(1)]	31.80%	35.50%	29.33%	29.96%	30.49%	32.44%
19) Combined Loss & Expense Ratio	57.35%	96.98%	94.96%	38.61%	77.37%	64.70%
20) Net Underwriting Gain or (Loss) [(1)-(10)-(18)]	$1,801,406	$115,030	$242,271	$2,892,674	$2,043,677	$3,007,704
21) Allocated Investment Income/(Loss)	$344,955	$239,032	$327,580	$169,981	$672,535	$409,014
22) Net Income/(Loss) after Investment [(20)+(21)]	$2,146,361	$354,062	$569,851	$3,062,655	$2,716,212	$3,416,717

EXHIBIT V

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 **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
# OF INSURERS REPORTING FDC INFO.	14	14	9	8
1) Premiums Earned	$1,903,932	$1,798,565	$2,319,383	$2,009,334
2) Premiums Written	$1,924,831	$1,816,887	$2,373,142	$2,102,853

Number of Claims:

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
3) Outstanding at Beginning of Year	16	21	22	45
4) New - During Reporting Period	43	21	93	32
5) Closed During Reporting Period	36	19	74	29
6) Outstanding at End of Year	23	23	41	48
7) Total Losses Incurred	($304,598)	$16,247	$912,550	$1,748,024
8) Loss Ratio (7)/(1)	-16.00%	0.90%	39.34%	87.00%
9) Loss Adjustment Expenses (LAE)	$275,443	$209,496	$195,329	$367,219
10) Total Losses Incurred + LAE	($29,155)	$225,742	$1,107,879	$2,115,243
11) Loss & LAE Ratio (10)/(1)	-1.53%	12.55%	47.77%	105.27%

Number of Policies:

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
12) In-Force at Beginning of Year	8,606	8,944	3,470	3,235
13) Written During the Year	3,442	3,652	672	538
14) Cancelled During the Year	470	694	144	240
15) NonRenewed During the Year	2,783	3,468	541	16
16) In-Force at End of Year	8,795	8,434	3,457	3,517

EXHIBIT V (continued)

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

17) Allocation of Expenses:

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**	CALENDAR YEAR **2007**	CALENDAR YEAR **2008**
a. Commissions	$326,443	$320,433	$491,621	$465,310
b. Other Acquisition Costs	$118,916	$129,441	$101,301	$112,356
c. General Expenses	$76,789	$95,653	$120,021	$122,097
d. Taxes, Licenses, Fees	$48,381	$48,092	$59,713	$58,504
18) Total Underwriting Expenses	$570,529	$593,619	$772,656	$758,265
Total Expense Ratio [(18)/(1)]	29.97%	33.01%	33.31%	37.74%
19) Combined Loss & Expense Ratio	28.43%	45.56%	81.08%	143.01%
20) Net Underwriting Gain or (Loss) [(1)-(10)-(18)]	$1,362,558	$979,204	$438,848	($864,174)
21) Allocated Investment Income/(Loss)	$159,023	$99,203	$185,932	$139,830
22) Net Income/(Loss) after Investment [(20)+(21)]	$1,521,581	$1,078,406	$624,780	($724,344)

Average Written Premium Per Policy

The rates 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 2008. The AWPs were calculated after removing the direct written premium for insurers that could not provide a policy written count.

EXHIBIT VI

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

* *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.

CIC §11555.2: MALPRACTICE INSURANCE -- DENTAL, MEDICAL, and LEGAL

Under CIC §11555.2, insurers transacting insurance covering liability for malpractice of any person licensed under the Dental Practice Act, the Medical Practice Act, or the State Bar Act, shall report specified statistics to the commissioner, by profession and by medical specialty, upon request of the commissioner.

CALIFORNIA LEGAL PROFESSIONAL LIABILITY INSURANCE REPORT - 2008

CIC §11555.2 requires each insurer transacting insurance covering liability for malpractice of any person licensed under the State Bar Act (Chapter 4 [commencing with Section 6000] of Division 3 of the Business and Professions Code) to file this report. The amounts reported reflect only direct business written in California and are filed on a group basis. Since the due date for the 2009 reports is July 1, 2010, at the time this Commissioner's Report was prepared, the 2009 data was not yet submitted. The 2009 summary will be available in next year's report.

For 2008, 28 companies/groups reported data under this section. Twenty-four (24) insurers reported writing claims-made policies, 2 wrote occurrence policies, and 2 wrote both.

Group / Company Name	Direct Written Premium	Direct Earned Premium	Direct Incurred Losses	Loss Ratio
2008: 28 Insurers Reporting	$200,738,110	$203,740,910	$75,461,487	37.04%
2007: 23 Insurers Reporting	$203,624,753	$208,165,179	$101,161,637	48.60%

CALIFORNIA LEGAL PROFESSIONAL LIABILITY INSURANCE: Top 10 Writers – 2008

Group / Company Name	Market Share	Direct Written Premium	Direct Earned Premium	Direct Incurred Losses	Loss Ratio
Lawyers' Mutual Ins. Co.	23.23%	$46,631,000	$47,591,000	$18,514,000	38.90%
CNA Insurance Group	17.35%	$34,823,739	$34,042,784	$17,548,335	51.55%
Arch Insurance Company	14.43%	$28,965,149	$30,148,516	$6,184,390	20.51%
Greenwich Ins. Co.	10.09%	$20,255,969	$21,322,437	$4,968,451	23.30%
Carolina Casualty Ins. Co.	8.74%	$17,552,159	$17,512,007	$14,058,358	80.28%
Chubb Group	8.01%	$16,075,962	$16,604,519	$9,968,084	60.03%
Zurich North America Group	6.13%	$12,298,504	$12,037,487	$8,523,682	70.81%
State National Ins Co., Inc.	2.58%	$5,179,991	$5,028,784	$1,938,497	38.55%
Great American Ins. Co.	2.36%	$4,735,938	$5,283,478	($2,305,848)	-43.64%
AXIS Specialty Group	1.91%	$3,826,062	$3,675,912	$4,851,371	131.98%
Top 10 Insurers	94.82%	$190,344,473	$193,246,924	$84,249,320	43.60%
GRAND TOTAL	**100.00%**	**$200,738,110**	**$203,740,910**	**$75,461,487**	**37.04%**

2008 LEGAL PROFESSIONAL LIABILITY REPORT: SUMMARY OF PREMIUMS & EXPENSES

Calendar Year	Total # of Lawyers Written during 2008 [1]	Direct Premiums Written [2]	Direct Premiums Earned [3]	Direct Losses Incurred [4]	Loss Ratio	Defense & Cost Containment Exp Incurred [5]	Incurred Losses & DCCE Ratio [6]
2008	58,400	$200,738,110	$203,740,910	$75,461,487	37.04%	$58,913,924	65.95%
2007	58,135	$209,202,438	$213,577,606	$180,305,608	84.42%	$63,529,326	114.17%
2006	63,436	$222,884,892	$220,998,161	$118,519,680	53.63%	$60,491,004	81.00%

Note [1]: # of lawyers – Not Available from 1 insurer

Calendar Year	Adjusting and Other Expenses Incurred [7]	Commissions & Brokerage Expenses Incurred [8]	Taxes, Licenses & Fees Incurred [9]	Other Acquisitions, Field Supervision, Collection Expenses Incurred [10]	General Expenses Incurred [11]	Total Underwriting Expenses [12]	Combined Loss + Expenses Ratio [13]
2008	$9,620,805	$23,322,841	$4,377,469	$6,272,776	$11,320,494	$54,914,384	92.91%
2007	$8,961,116	$21,386,946	$3,177,677	$3,844,622	$10,270,969	$47,641,330	136.47%
2006	$9,159,563	$17,614,687	$3,521,241	$4,293,326	$10,153,032	$44,741,850	101.25%

Field Description & Calculation for 2008 Legal Professional Liability Report: Summary of Premiums & Expenses

1 = Total # of Lawyers Written during 2008
2 = Direct Premiums Written
3 = Direct Premiums Earned
4 = Direct Losses Incurred
Loss Ratio [4] \ [3]
5 = Defense & Cost Containment Expenses (DCCE) Incurred
6 = Incurred Losses & DCCE Ratio [4 + 5] / [3]
7 = Adjusting and Other Expenses Incurred
8 = Commissions & Brokerage Expenses Incurred
9 = Taxes, Licenses & Fees Incurred
10 = Other Acquisitions, Field Supervision, Collection Expenses Incurred
11 = General Expenses Incurred
12 = Total Underwriting Expenses [7+8+9+10+11]
13 = Combined Loss + Expenses Ratio [4 + 5 + 12] / [3]

SUMMARY OF: CLAIMS CLOSED IN 2008 – DIRECT PAYMENTS

Indemnity Claim Size Interval	Number of Claims [A]	Total Indemnity Paid for Claims in Interval [B]	Total DCCE Paid for Claims in Interval [C]
$ 0 *	847	$0	$0
$ 0 *	445	$0	$18,749,125
$ 1 - 9,999	62	$284,693	$1,950,156
$ 10,000 - 49,999	166	$3,962,499	$4,222,674
$ 50,000 - 99,999	91	$6,184,177	$3,326,062
$ 100,000 - 249,999	105	$14,603,112	$4,585,547
$ 250,000 - 499,999	50	$11,577,180	$2,804,217
$ 500,000 - 749,999	33	$10,570,107	$3,282,839
$ 750,000 - 999,999	9	$6,382,157	$863,752
$ 1,000,000 and over	22	$34,698,708	$3,655,557
TOTAL	1,830	$88,262,632	$43,439,929

Note (*): The claims closed in 2008, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses Paid and Claims without Defense and Cost Containment Expenses Paid.

CLAIMS CLOSED WITH PAYMENT TO THE CLAIMANT DURING 2008

Occurrence Year	# of Claims [1]	Total Monetary Amount Paid [2]	Average Claim Payment [3	Defense & Cost Containment Exp Paid [4]	Loss + DCCE Paid [5]	Average Loss & DCCE Paid [6]
Pre 2000	14	$2,712,072	$193,719	$224,285	$2,936,357	$209,740
2000	6	$1,956,178	$326,030	$289,102	$2,245,280	$374,213
2001	9	$1,811,079	$201,231	$459,401	$2,270,480	$252,276
2002	19	$6,259,984	$329,473	$1,542,807	$7,802,791	$410,673
2003	24	$6,719,574	$279,982	$1,965,208	$8,684,782	$361,866
2004	57	$10,965,797	$192,382	$3,615,765	$14,581,562	$255,817
2005	96	$21,364,048	$222,542	$6,922,916	$28,286,965	$294,656
2006	146	$18,623,400	$127,558	$6,479,313	$25,102,714	$171,936
2007	145	$16,790,465	$115,796	$3,005,794	$19,796,259	$136,526
2008	24	$1,010,037	$42,085	$143,427	$1,153,464	$48,061
TOTAL	540	$88,212,634	$163,357	$24,648,019	$112,860,654	$209,001

CLAIMS CLOSED WITHOUT PAYMENT TO THE CLAIMANT DURING 2008

Occurrence Year	# of Claims [7]	Defense & Cost Containment Exp Paid [8]	Average DCCE Paid [9]	Avg. Claim Payments: ALL Claims [10]
Pre 2000	46	$746,945	$16,238	$61,388
2000	9	$5,106,813	$567,424	$490,140
2001	20	$1,446,099	$72,305	$128,158
2002	25	$1,444,331	$57,773	$210,162
2003	25	$685,564	$27,423	$191,232
2004	78	$2,225,312	$28,530	$124,495
2005	138	$2,226,565	$16,135	$130,400
2006	217	$2,639,509	$12,164	$76,425
2007	447	$1,953,996	$4,371	$36,740
2008	296	$240,968	$814	$4,358
TOTAL	1,301	$18,716,101	$14,386	$71,470

Note: Defense & Cost Containment Expenses (DCCE) were formerly known as Allocated Loss Adjustment Expenses (ALAE).

Field Description & Calculation for Claims Closed With and Without Payment to the Claimant During 2008

1 = # of Claims
2 = Total Monetary Amount Paid
3 = Average Claim Payment [2] / [1]
4 = Defense & Cost Containment Exp Paid
5 = Loss + DCCE Paid [2] + [4]
6 = Average Loss & DCCE Paid [5] / [1]
7 = # of Claims
8 = Defense & Cost Containment Exp Paid
9 = Average DCCE Paid [8] / [7]
10 = Avg. Claim Payments: ALL Claims {[5]+[8]}/{[1]+[7]}

Occurrence Year	CLAIMS REPORTED for FIRST TIME & REOPENED CLAIMS		CLAIMS OUTSTANDING as of 12/31/2008				MONETARY AMOUNT PAID ON CLAIMS DURING 2008	
	# of Claims Reported for 1st Time During 2008	# of Claims Re-Opened During 2008	# of Claims Outstanding	Dir Amt Reserved for Loss on Reported Claims (Case)	Dir Amt Reserved for DCCE on Reported Claims (Case)	Amount of IBNR Reserve for Loss & DCCE *	Monetary Amount Paid on Claims	Defense & Cost Containment Expenses Paid
Pre 2000	28	27	72	$3,102,144	$1,196,486	$693,343	$5,845,174	$2,990,650
2000	4	17	17	$601,129	$456,313	$1,359,936	$2,208,905	$1,083,207
2001	5		41	$3,566,638	$1,471,571	$1,243,250	$1,704,473	$2,535,738
2002	11	5	39	$4,629,909	$2,380,892	$1,674,281	$5,121,364	$2,939,943
2003	17	8	73	$14,085,088	$1,838,437	$2,478,764	$4,200,357	$2,846,053
2004	37	26	123	$10,452,471	$4,498,211	$9,895,541	$13,416,412	$5,550,423
2005	59	27	153	$11,599,797	$4,886,487	$11,909,235	$7,279,136	$7,043,019
2006	129	59	265	$12,204,457	$5,151,391	$22,429,025	$17,638,626	$10,468,956
2007	498	35	431	$13,634,662	$7,556,650	$38,174,512	$18,403,800	$12,697,272
2008	1,428	15	655	$10,015,037	$6,874,212	$49,948,588	$4,392,387	$2,339,470
TOTAL	2,216	219	1,869	$83,891,332	$36,310,649	$206,460,275	$80,210,634	$50,494,731

** Include Bulk Reserve for Adverse Development on Case Reserves*

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE REPORT: 2008

CIC §11555.2 requires each insurer transacting insurance covering liability for malpractice of any person licensed under the Dental Practice Act (Chapter 4 [commencing with Section 1600] of Division 2 of the Business and Professions Code) or under the Medical Practice Act (Chapter 5 [commencing with Section 2000] of Division 2 of the Business and Professions Code) to file this report. The amounts reported reflect only business written in California and are filed on a group basis. All amounts reported are direct liability with no deduction for reinsurance.

A separate report is required for the following designated type of health care providers as defined in Supplement A to Schedule T of the Annual Statement:

(a) Physicians - including Surgeons and Osteopaths;
(b) Hospitals;
(c) Other Health Care Professionals - including Dentists; and
(d) Other Health Care Facilities.

Since the deadline for the 2009 reports is July 1, 2010, at the time this Commissioner's Report was prepared, the 2009 data was still being submitted. The 2009 summary will be available in next year's report.

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2008
SUMMARY OF PREMIUMS AND EXPENSES

ALL TYPES OF HEALTH CARE PROVIDERS COMBINED -- 49 Companies/Groups Reporting Data

	2006	2007	2008
# of Providers/ Beds Insured *	292,426	354,767	352,610
Direct Premiums Written	$719,702,818	$691,461,206	$676,654,935
Direct Premiums Earned	$700,625,423	$696,046,422	$676,098,855
Direct Losses Incurred	$212,524,782	$200,277,956	$109,109,758
LOSS RATIO	**30.33%**	**28.77%**	**16.14%**
Defense Cost Containment Exp Incurred	$191,635,243	$164,817,642	$127,879,490
INC LOSS + DCCE RATIO	**57.69%**	**52.45%**	**35.05%**
Adjusting & Other Exp Incurred	$60,621,971	$55,057,272	$56,066,104
Commissions & Brokerage Exp Incurred	$42,019,804	$41,877,306	$39,804,981
Taxes, Licenses & Fees Incurred	$17,729,151	$16,889,406	$16,089,862
Other Acquisition, Field Supervision Exp Incurred	$21,374,804	$19,115,367	$19,136,966
General Expenses Incurred	$58,369,067	$56,066,079	$58,071,450
Underwriting Expense	$200,114,798	$189,005,430	$189,169,364
COMBINED RATIO = (Loss+Exps)/EP	**86.25%**	**79.61%**	**63.03%**

** Not all insurers were able to provide "# of beds / providers insured"*

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2008

PHYSICIANS

	2006	2007	2008
# of Insurers Reporting Data	25	25	28
# Insurers Reporting w/ DWP > $0	19	19	20
# of Providers/ Beds Insured *	42,568[*1]	40,243[*1]	39,992
Direct Premiums Written	$578,745,148	$555,638,523	$535,537,760
Direct Premiums Earned	$561,990,207	$562,445,709	$534,864,562
Direct Losses Incurred	$163,699,595	$166,307,932	$87,123,543
LOSS RATIO	**29.13%**	**29.57%**	**16.29%**
Defense & Cost Containment Exp Incurred	$161,472,986	$123,921,625	$96,406,885
INC LOSS + DCCE RATIO	**57.86%**	**51.60%**	**34.31%**
Adjusting & Other Exp Incurred	$59,594,937	$47,807,766	$48,390,079
Commissions & Brokerage Exp Incurred	$24,006,367	$27,960,083	$21,386,811
Taxes, Licenses & Fees Incurred	$13,916,582	$13,574,444	$12,682,634
Other Acquisition, Field Supervision Exp Incurred	$15,551,109	$14,617,897	$14,085,552
General Expenses Incurred	$45,849,664	$43,912,373	$44,911,762
Underwriting Expense	$158,918,659	$147,872,563	$141,456,838
COMBINED RATIO = (Loss+Exps)/EP	**86.14%**	**77.89%**	**60.76%**

** Missing # of beds/providers from this amount of insurers.*

OTHER HEALTH CARE PROFESSIONALS

	2006	2007	2008
# of Insurers Reporting Data	19	19	23
# Insurers Reporting w/ DWP > $0	16	15	19
# of Providers/ Beds Insured *	191,685*2	276,656*2	302,278*1
Direct Premiums Written	$101,330,573	$103,961,964	$105,384,454
Direct Premiums Earned	$99,165,676	$102,404,734	$105,130,822
Direct Losses Incurred	$23,260,496	$35,916,185	$27,719,335
LOSS RATIO	**23.46%**	**35.07%**	**26.37%**
Defense & Cost Containment Exp Incurred	$20,295,231	$31,514,938	$22,694,282
INC LOSS + DCCE RATIO	**43.92%**	**65.85%**	**47.95%**
Adjusting & Other Exp Incurred	$8,479,801	$4,157,706	$1,857,298
Commissions & Brokerage Exp Incurred	$14,357,395	$10,724,204	$14,705,540
Taxes, Licenses & Fees Incurred	$2,797,256	$2,642,379	$2,768,412
Other Acquisition, Field Supervision Exp Incurred	$4,604,710	$3,364,588	$3,976,852
General Expenses Incurred	$9,154,444	$10,209,892	$10,239,993
Underwriting Expense	$39,393,605	$31,098,769	$33,548,095
COMBINED RATIO = (Loss+Exps)/EP	**83.65%**	**96.22%**	**79.86%**

- *Missing # of beds/providers from this amount of insurers.*

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2008

HOSPITALS

	2006	2007	2008
# of Insurers Reporting Data	16	15	16
# Insurers Reporting w/ DWP > $0	6	7	6
# of Providers/ Beds Insured *	11,443*2	31,415*4	4,963*2
Direct Premiums Written	$27,892,975	$21,587,864	$23,125,191
Direct Premiums Earned	$27,059,268	$20,560,100	$23,642,508
Direct Losses Incurred	$20,042,748	($4,990,250)	($5,790,582)
LOSS RATIO	**74.07%**	**-24.27%**	**-24.49%**
Defense & Cost Containment Exp Incurred	$4,596,422	$6,352,195	$6,275,662
INC LOSS + DCCE RATIO	**91.06%**	**6.62%**	**2.05%**
Adjusting & Other Exp Incurred	($8,011,653)	($1,628,730)	$2,695,936
Commissions & Brokerage Exp Incurred	$2,676,656	$2,010,919	$2,204,686
Taxes, Licenses & Fees Incurred	$618,142	$387,464	$351,193
Other Acquisition, Field Supervision Exp Incurred	$534,780	$441,235	$377,204
General Expenses Incurred	$1,734,257	$1,429,246	$1,856,387
Underwriting Expense	($2,447,818)	$2,640,134	$7,485,406
COMBINED RATIO = (Loss+Exps)/EP	**82.01%**	**19.47%**	**33.71%**

** Missing # of beds/providers from this amount of insurers.*

OTHER HEALTH CARE FACILITIES

	2006	2007	2008
# of Insurers Reporting Data	17	18	20
# Insurers Reporting w/ DWP > $0	10	8	10
# of Providers/ Beds Insured *	46,730*2	6,453*1	5,377*3
Direct Premiums Written	$11,734,122	$10,272,855	$12,607,530
Direct Premiums Earned	$12,410,272	$10,635,879	$12,460,963
Direct Losses Incurred	$5,521,943	$3,044,089	$57,463
LOSS RATIO	**44.49%**	**28.62%**	**0.46%**
Defense & Cost Containment Exp Incurred	$5,270,604	$3,028,884	$2,502,661
INC LOSS + DCCE RATIO	**86.96%**	**57.10%**	**20.55%**
Adjusting & Other Exp Incurred	$558,886	$4,720,530	$3,122,790
Commissions & Brokerage Exp Incurred	$979,386	$1,182,099	$1,507,945
Taxes, Licenses & Fees Incurred	$397,172	$285,120	$287,623
Other Acquisition, Field Supervision Exp Incurred	$684,206	$691,647	$697,358
General Expenses Incurred	$1,630,702	$514,568	$1,063,308
Underwriting Expense	$4,250,352	$7,393,964	$6,679,025
COMBINED RATIO = (Loss+Exps)/EP	**121.21%**	**126.62%**	**74.14%**

** Missing # of beds/providers from this amount of insurers.*

The following exhibits show the total premiums and losses reported under Line 11 – Medical Professional Liability (*source: NAIC database using data from the insurers' Annual Statements*).

For 2009, there was an increase in the number of "licensed" insurance companies reporting under Line 11, due to the inclusion of more risk retention groups (RRGs). A total of 124 licensed insurance companies reported data under this line. Of this amount, 64 companies had Direct Written Premium greater than $0. Of these 64 companies, only 18 had Direct Written Premium greater than $5,000,000. The top 10 insurers (including RRGs) for 2009 wrote approximately 83.1% of all California medical professional liability business written by licensed insurers.

California Medical Malpractice Liability Insurance
(Source: NAIC Database, as of 04/12/10)

Year		Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct Defense & Cost Containment Exps Incurred	DLI+DCC Incurred Ratio
2009	64 Companies w/ DWP > $0	$671,655,179	$650,084,668	$161,117,035	24.78%	$147,704,652	47.50%
	99 Insurance Companies	$565,611,892	$544,185,600	$105,698,975	19.42%	$128,725,151	43.08%
	25 Risk Retention Groups (RRGs)	$106,042,645	$105,884,659	$36,501,037	34.47%	$20,654,641	53.98%
2009	Total Reporting: 124 Insurers/RRGs	$671,654,537	$650,070,259	$142,200,012	21.87%	$149,379,792	44.85%
2008	36 Companies w/ DWP > $0	$610,446,385	$611,448,969	$100,485,324	16.43%	$116,220,676	35.44%
2008	Total Reporting: 94 Companies	$610,392,276	$611,413,738	$89,471,925	14.63%	$116,796,715	33.74%

Note: The increase in the number of Licensed Companies Reporting in 2009 is due from RRGs being included as "licensed" in the 2009 NAIC database. The 2008 database shows only 1 RRG as licensed; the others were shown as writing, but not designated as licensed.

TOP 10 MEDICAL PROFESSIONAL LIABILITY WRITERS IN CALIFORNIA (including RRGs): YEAR 2009
(Source: NAIC Database as of 4/12/10)

#	Company Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct Defense & Cost Containment Exps Incurred	DLI+DCCE Incurred Ratio
1	Doctors Co An Interins Exchange	$210,609,883	31.36%	$179,110,719	$17,931,436	10.01%	$45,004,019	35.14%
2	Norcal Mut Ins Co	$156,865,844	23.36%	$156,269,874	$46,439,827	29.72%	$38,058,011	54.07%
3	Medical Ins Exchange Of CA	$36,598,906	5.45%	$36,599,284	$9,275,321	25.34%	$7,128,397	44.82%
4	Medical Protective Co	$29,324,159	4.37%	$28,469,379	$13,626,385	47.86%	$4,289,044	62.93%
5	Dentists Ins Co	$29,238,078	4.35%	$28,856,269	$6,943,376	24.06%	$9,531,101	57.09%
6	California Healthcare Ins Co Inc RRG	$28,127,046	4.19%	$28,443,695	$15,160,566	53.30%	$2,991,235	63.82%
7	National Union Fire Ins Co Of Pitts	$19,314,217	2.88%	$19,717,579	$10,023,607	50.84%	$2,994,349	66.02%
8	Medamerica Mut RRG Inc	$18,558,025	2.76%	$18,626,716	$4,323,370	23.21%	$5,239,691	51.34%
9	American Cas Co Of Reading PA	$15,596,052	2.32%	$15,416,839	$9,400,826	60.98%	$2,400,423	76.55%
10	Health Providers Ins Recip RRG	$14,001,494	2.08%	$13,709,018	$3,175,977	23.17%	$2,222,922	39.38%
	Top 10 MedProfLiab Writers (including RRGs)	$558,233,704	83.11%	$525,219,372	$136,300,691	25.95%	$119,859,192	48.77%

TOP 10 MEDICAL PROFESSIONAL LIABILITY WRITERS IN CALIFORNIA (excluding RRGs): YEAR 2009

Source: NAIC Database (as of 4/12/10)

#	Company Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct Defense & Cost Containment Exps Incurred	DLI+DCCE Incurred Ratio
1	Doctors Co An Interins Exchange	$210,609,883	37.24%	$179,110,719	$17,931,436	10.01%	$45,004,019	35.14%
2	Norcal Mut Ins Co	$156,865,844	27.73%	$156,269,874	$46,439,827	29.72%	$38,058,011	54.07%
3	Medical Ins Exchange Of CA	$36,598,906	6.47%	$36,599,284	$9,275,321	25.34%	$7,128,397	44.82%
4	Medical Protective Co	$29,324,159	5.18%	$28,469,379	$13,626,385	47.86%	$4,289,044	62.93%
5	Dentists Ins Co	$29,238,078	5.17%	$28,856,269	$6,943,376	24.06%	$9,531,101	57.09%
6	National Union Fire Ins Co Of Pitts	$19,314,217	3.41%	$19,717,579	$10,023,607	50.84%	$2,994,349	66.02%
7	American Cas Co Of Reading PA	$15,596,052	2.76%	$15,416,839	$9,400,826	60.98%	$2,400,423	76.55%
8	SCPIE Ind Co	$10,784,702	1.91%	$14,281,089	($6,408,501)	-44.87%	$1,443,875	-34.76%
9	Professional Underwriters Liab Ins Company	$9,911,242	1.75%	$9,274,280	($2,398,209)	-25.86%	$617,157	-19.20%
10	ACE Amer Ins Co	$7,691,553	1.36%	$7,735,610	$5,886,757	76.10%	$2,113,433	103.42%
	Top 10 MedProfLiab Writers (excluding RRGs)	$525,934,636	92.98%	$495,730,922	$110,720,825	22.33%	$113,579,809	45.25%

TOP 10 MEDICAL PROFESSIONAL LIABILITY WRITERS IN CALIFORNIA: YEAR 2008

Source: NAIC Database (as of 4/16/09)

#	Company Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct Defense & Cost Containment Exps Incurred	DLI+DCCE Incurred Ratio
1	Norcal Mutual Ins. Co.	$163,314,374	26.75%	$164,523,202	$30,028,405	18.25%	$36,842,463	40.65%
2	Doctors Co. An Interins. Exch.	$151,261,024	24.78%	$148,456,629	$27,252,030	18.36%	$24,048,182	34.56%
3	SCPIE Indemnity Co.	$87,751,988	14.38%	$87,885,453	$17,140,297	19.50%	$12,628,160	33.87%
4	Medical Ins. Exch. Of CA	$37,864,332	6.20%	$38,053,520	($3,879,058)	-10.19%	$5,020,629	3.00%
5	Dentists Ins. Co.	$28,532,495	4.67%	$27,811,584	$5,949,167	21.39%	$7,686,111	49.03%
6	Medical Protective Company	$28,123,839	4.61%	$26,836,143	$8,345,453	31.10%	$6,010,268	53.49%
7	American Healthcare Ind. Co.	$25,983,208	4.26%	$28,228,538	$4,790,121	16.97%	$6,432,283	39.76%

TOP 10 MEDICAL PROFESSIONAL LIABILITY WRITERS IN CALIFORNIA: YEAR 2008 (continued)

Source: NAIC Database (as of 4/16/09)

#	Company Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct Defense & Cost Containment Exps Incurred	DLI+DCCE Incurred Ratio
9	American Cas. Co. of Reading PA	$14,923,219	2.44%	$14,875,230	$2,100,677	14.12%	$3,602,266	38.34%
10	Professional Undrwtrs Liab. I. C.	$10,799,148	1.77%	$11,745,711	$3,846,982	32.75%	$1,015,688	41.40%
	Top 10 Med Mal Writers	$564,932,499	92.54%	$558,676,481	$102,296,388	18.31%	$105,405,390	37.18%

DISTRIBUTION BY SIZE OF PAYMENT FOR CLAIMS CLOSED DURING 2008

ALL HEALTH CARE PROVIDERS COMBINED

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims In Interval	Total DCCE Paid for Claims In Interval
$ 0 w/ DCCE (1)	4,322	($1,000)	$83,065,929
$ 0 w/out DCCE (1)	2,754	$0	$0
$ 1 - 9,999	472	$1,773,470	$3,073,454
$ 10,000 - 49,999	424	$10,356,131	$14,619,141
$ 50,000 - 99,999	177	$11,092,054	$9,363,130
$ 100,000 - 249,999	224	$31,210,753	$13,991,034
$ 250,000 - 499,999	105	$33,066,357	$9,784,074
$ 500,000 - 749,999	35	$19,208,818	$4,806,413
$ 750,000 - 999,999	33	$29,576,110	$4,011,476
$ 1,000,000 and over	40	$51,926,999	$6,419,693
TOTAL	8,586	$188,209,691	$149,134,343

Notes: (1) The claims closed during 2008, without indemnity payment, should be broken down in two categories: Claims with Defense and Cost Containment Expenses Paid and "Claims without Defense and Cost Containment Expenses Paid."

PHYSICIANS

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims In Interval	Total DCCE Paid for Claims In Interval
$ 0 w/ DCCE (1)	3,509	$0	$72,050,419
$ 0 w/out DCCE (1)	2,063	$0	$0
$ 1 - 9,999	88	$330,939	$858,181
$ 10,000 - 49,999	252	$5,971,322	$10,684,602
$ 50,000 - 99,999	110	$6,263,999	$6,179,230
$ 100,000 - 249,999	163	$22,320,130	$10,981,312
$ 250,000 - 499,999	85	$26,781,357	$7,964,878
$ 500,000 - 749,999	28	$15,071,038	$4,046,106
$ 750,000 - 999,999	29	$25,632,490	$3,795,845
$ 1,000,000 and over	36	$46,176,999	$6,022,546
TOTAL	6,363	$148,548,273	$122,583,119

OTHER HEALTH CARE PROFESSIONALS

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims In Interval	Total DCCE Paid for Claims In Interval
$ 0 w/ DCCE (1)	736	$0	$9,308,375
$ 0 w/out DCCE (1)	614	$0	$0
$ 1 - 9,999	357	$1,381,209	$2,038,652
$ 10,000 - 49,999	158	$4,006,310	$3,337,045
$ 50,000 - 99,999	58	$4,138,463	$2,619,954
$ 100,000 - 249,999	53	$7,608,622	$2,625,570
$ 250,000 - 499,999	14	$4,510,000	$1,079,458
$ 500,000 - 749,999	4	$2,090,000	$196,720
$ 750,000 - 999,999	1	$1,000,000	$63,966
$ 1,000,000 and over	2	$2,500,000	$202,313
TOTAL	1,997	$27,234,604	$21,472,053

HOSPITALS

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims In Interval	Total DCCE Paid for Claims In Interval
$ 0 w/ DCCE (1)	46	$0	$735,089
$ 0 w/out DCCE (1)	50	$0	$0
$ 1 - 9,999	22	$42,222	$122,305
$ 10,000 - 49,999	5	$124,999	$374,391
$ 50,000 - 99,999	7	$531,592	$347,206
$ 100,000 - 249,999	4	$612,001	$164,793
$ 250,000 - 499,999	4	$1,125,000	$210,050
$ 500,000 - 749,999	1	$634,587	$142,010
$ 750,000 - 999,999	2	$1,993,620	$25,906
$ 1,000,000 and over	1	$2,250,000	$29,698
TOTAL	142	$7,314,021	$2,151,448

OTHER HEALTH CARE FACILITIES

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims In Interval	Total DCCE Paid for Claims In Interval
$ 0 w/ DCCE (1)	31	($1,000)	$972,046
$ 0 w/out DCCE (1)	27	$0	$0
$ 1 - 9,999	5	$19,100	$54,316
$ 10,000 - 49,999	9	$253,500	$223,104
$ 50,000 - 99,999	2	$158,000	$216,739
$ 100,000 - 249,999	4	$670,000	$219,358
$ 250,000 - 499,999	2	$650,000	$529,688
$ 500,000 - 749,999	2	$1,413,193	$421,577
$ 750,000 - 999,999	1	$950,000	$125,759
$ 1,000,000 and over	1	$1,000,000	$165,136
TOTAL	84	$5,112,793	$2,927,723

Notes: (1) The claims closed during 2008, without indemnity payment, should be broken down in two categories: Claims with Defense and Cost Containment Expenses Paid and "Claims without Defense and Cost Containment Expenses Paid."

2008 CLAIMS DATA: ALL HEALTH CARE PROVIDERS COMBINED

CLAIMS CLOSED WITH PAYMENT TO THE CLAIMANT DURING 2008

Occurrence Year	Number of Claims [1]	Total Monetary Amount Paid [2]	Average Claim Payment [3]	Defense & Cost Containment Exp Paid [4]	Loss & DCC Expenses Paid [5]	Average Loss & DCCE Paid [6]
Pre 2000	23	$2,802,983	$121,869	$1,389,295	$4,192,278	$182,273
2000	10	$7,220,000	$722,000	$1,169,096	$8,389,096	$838,910
2001	22	$2,743,936	$124,724	$2,538,707	$5,282,643	$240,120
2002	51	$11,253,049	$220,648	$5,855,947	$17,108,996	$335,471
2003	81	$20,460,887	$252,604	$7,859,803	$28,320,690	$349,638
2004	185	$36,306,926	$196,254	$12,592,294	$48,899,220	$264,320
2005	364	$45,566,638	$125,183	$18,629,333	$64,195,971	$176,363
2006	405	$46,432,257	$114,648	$12,901,969	$59,334,226	$146,504
2007	268	$14,381,987	$53,664	$3,063,082	$17,445,069	$65,094
2008	101	$1,041,029	$10,307	$68,893	$1,109,921	$10,989
TOTAL	1,510	$188,209,692	$124,642	$66,068,417	$254,278,110	$168,396

CLAIMS CLOSED W/OUT PAYMENT to the CLAIMANT DURING 2008

Occurrence Year	Number of Claims [7]	Defense and Cost Containment Exp Paid [8]	Average DCCE Paid [9]	Avg. Claim Payment for ALL Claims Combined [10]
Pre 2000	176	$3,760,085	$21,364	$39,962
2000	81	$1,560,072	$19,260	$109,332
2001	117	$4,654,496	$39,782	$71,490
2002	136	$4,116,923	$30,271	$113,508
2003	273	$9,698,705	$35,526	$107,399
2004	563	$14,836,047	$26,352	$85,208
2005	1,279	$22,781,479	$17,812	$52,938
2006	2,093	$17,081,981	$8,161	$30,591
2007	1,853	$3,642,038	$1,965	$9,942
2008	506	$934,100	$1,846	$3,367
TOTAL	7,077	$83,065,926	$11,737	$39,285

Field Description and Calculation for Claims Closed With and Without Payment to the Claimant During 2008.

1 = Number of Claims
2 = Total Monetary Amount Paid
3 = Average Claim Payment [2] / [1]
4 = Defense & Cost Containment Exp Paid
5 = Loss & DCC Expenses Paid [2] + [4]
6 = Average Loss & DCCE Paid [5] / [1]
7 = Number of Claims
8 = Defense and Cost Containment Exp Paid
9 = Average DCCE Paid [8] / [7]
10 = Avg. Claim Payment for ALL Claims Combined [5+8] / [1+7]

Occurrence Year	CLAIMS REPORTED for 1st TIME / REOPENED in 2008		CLAIMS OUTSTANDING as of 12/31/2008				MONETARY AMOUNT PAID ON CLAIMS DURING 2008	
	# Claims Reported for 1st Time During 2008	# Claims ReOpened During 2008	# of Claims Outstanding	Direct Amount Reserved for Loss on Reported Claims (Case)	Direct Amount Reserved for DCCE on Reported Claims (Case)	Amount of IBNR Reserve for Loss & DCCE *	Monetary Amount Paid on Claims	Defense & Cost Containment Expenses Paid
Pre 2000	64	19	299	$9,727,156	$3,318,358	$3,946,950	$3,656,473	$3,423,868
2000	52	11	129	$10,320,601	$2,473,807	$9,442,750	$7,878,072	$2,968,340
2001	44	10	131	$8,112,116	$1,271,017	$9,316,373	$3,470,005	$3,649,482
2002	98	24	199	$10,316,794	$2,939,331	$15,260,362	$11,980,913	$6,024,695
2003	106	25	255	$13,614,272	$3,947,044	$18,248,924	$17,489,697	$12,537,363
2004	199	50	452	$35,247,384	$7,243,770	$43,151,306	$34,137,505	$19,646,573
2005	544	152	1,000	$53,977,768	$13,424,483	$73,953,950	$41,389,621	$38,211,634
2006	1,304	169	1,923	$100,692,401	$27,303,138	$134,690,053	$49,924,546	$48,719,966
2007	3,612	148	2,940	$108,725,853	$33,470,160	$206,145,427	$18,837,643	$21,477,893
2008	2,594	26	1,868	$23,696,104	$14,009,425	$192,272,956	$3,071,956	$2,678,731
TOTAL	8,617	634	9,196	$374,430,448	$109,400,533	$706,429,052	$191,836,430	$159,338,546

** Include Bulk Reserve for Adverse Development on Case Reserves.*

2008 CLAIMS DATA: BY TYPE OF HEALTH CARE PROVIDER

CLAIMS CLOSED WITH PAYMENT TO THE CLAIMANT DURING 2008

Health Care Provider	Number of claims [1]	Total Monetary Amount Paid [2]	Average Claim Payment [3]	Defense & Cost Containment Exp Pd [4]	Loss & DCC Expenses Paid [5]	Average Loss & DCCE Paid [6]
PHYSICIANS	791	$148,548,274	$187,798	$50,532,699	$199,080,973	$251,683
OTHER PROF	647	$27,234,604	$42,094	$12,163,681	$39,398,285	$60,894
HOSPITALS	46	$7,314,021	$159,000	$1,416,359	$8,730,380	$189,791
OTHER FAC	26	$5,112,793	$196,646	$1,955,678	$7,068,471	$271,864
TOTAL	1,510	$188,209,692	$124,642	$66,068,417	$254,278,110	$168,396

CLAIMS CLOSED W/OUT PAYMENT to the CLAIMANT DURING 2008

Health Care Provider	Number of Claims [7]	Defense and Cost Containment Exp Paid [8]	Average DCCE Paid [9]	Avg. Claim Payment for ALL Claims Combined [10]
PHYSICIANS	5,572	$72,050,420	$12,931	$42,611
OTHER PROF	1,350	$9,308,371	$6,895	$24,390
HOSPITALS	97	$735,089	$7,578	$66,192
OTHER FAC	58	$972,046	$16,759	$95,720
TOTAL	7,077	$83,065,926	$11,737	$39,285

Field Description and Calculation for Claims Closed With and Without Payment to the Claimant During 2008.

1 = Number of Claims
2 = Total Monetary Amount Paid
3 = Average Claim Payment [2] / [1]
4 = Defense & Cost Containment Exp Paid
5 = Loss & DCC Expenses Paid [2] + [4]
6 = Average Loss & DCCE Paid [5] / [1]
7 = Number of Claims
8 = Defense and Cost Containment Exp Paid
9 = Average DCCE Paid [8] / [7]
10 = Avg. Claim Payment for ALL Claims Combined [5+8] / [1+7]

Health Care Provider	CLAIMS REPORTED for the FIRST TIME & CLAIMS REOPENED in 2008		CLAIMS OUTSTANDING as of 12/31/2008				MONETARY AMOUNT PAID ON CLAIMS DURING 2008	
	# Claims Reported for 1st Time During 2008	# Claims ReOpened During 2008	# of Claims Outstanding	Direct Amount Reserved for Loss on Reported Claims (Case)	Direct Amount Reserved for DCCE on Reported Claims (Case)	Amount of IBNR Reserve for Loss & DCCE *	Monetary Amount Paid on Claims	Defense & Cost Containment Expenses Paid
PHYSICIANS	5,794	392	7,068	$321,366,093	$88,548,392	$574,633,250	$155,580,946	$130,128,860
OTHER PROF	2,550	224	1,857	$41,567,459	$13,479,098	$84,000,248	$25,625,427	$23,847,542
HOSPITALS	186	16	153	$5,940,144	$3,554,102	$33,570,069	$6,418,035	$2,070,436
OTHER FAC	87	2	118	$5,556,752	$3,818,941	$14,225,485	$4,212,022	$3,291,708
TOTAL	8,617	634	9,196	$374,430,448	$109,400,533	$706,429,052	$191,836,430	$159,338,546

Notes: 1. Defense and Cost Containment Expenses (DCCE) were formerly known as Allocated Loss Adjustment Expenses (ALAE).

2. Adjusting and Other Expenses (AOE) were formerly known as Unallocated Loss Adjustment Expenses (ULAE).

3. LAE = DCCE + AOE (formerly LAE = ALAE + ULAE).

2009 ANNUAL REPORT

CONSUMER SERVICES AND MARKET CONDUCT BRANCH

Consumer Services and 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 five bureaus:

Consumer Services Division (CSD)

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

Market Conduct Division (MCD)

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

Table A: CSMCB 2009 Calendar Year Results

Consumer Telephone Calls Received (automated call-center calls)	212,567
Complaint Cases Opened	36,635
Complaint Cases Closed	38,481
Total Amount of Consumer Dollars Recovered	$89,130,819
Number of Exams Adopted by the Commissioner	207
Total Amount of Claims Dollars Recovered or Premium Returned to Consumers	$22,957,644
Penalties Resulting from MCD Legal Actions in 2009	$2,465,000
CSMCB Grand Total Amount (Consumer Dollars Recovered, Claims Dollars Recovered or Premium Returned to Consumers, and Penalties Resulting from Legal Actions in 2009)	**$114,553,463**

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 administrating 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 three bureaus within the division: the Consumer Communication Bureau (CCB), the Claims Services Bureau (CSB) and the Rating & Underwriting Services Bureau (RUSB). CCB is often referred to as the Hotline, and its staff responds to telephone calls received through the Department's toll-free phone line. In 2009, 105 fulltime staff are devoted to the complaint handing operation. This represents 9% of the 1247 total authorized positions in the Department.

The 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 written consumer complaints involving claims issues for all lines of insurance except Workers' Compensation, which are regulated by the Department of Industrial Relations in California. RUSB is responsible for investigating, evaluating, and resolving written 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.

The CSD retains records on all consumer complaints involving rating, underwriting and claims issues. This information is gathered and trend reports are developed with the goal of determining whether further action against the licensee should be taken. The Division collects and maintains a wide range of statistical information on complaints. On an annual basis it tracks: the number of complaints open and closed, types of alleged violations, amount of recoveries, number of complaints against insurers, etc. Additionally, the Division prepares complaint comparison studies for automobile, homeowner's and life products in order to rank insurers based on their frequency of complaints and whether those complaints were justified. A Justified Complaint Ratio is

used to determine which insurers are the worst performers. These statistics can lead to a number of actions, such as: enforcement action; referral of case to the CDI Legal Division for formal legal action; and initiation of a request for a market conduct examination. All legal actions taken by CDI are public information and are posted on the department's website. Insurers can appeal enforcement actions taken against them through the civil court system.

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 31 California wildfires in 2009, most of which did not result in major structural damage. However, three fires resulted in notable damages, the Station, Jesusita and 49er fires. The Division deployed 14 Officers to assist CalEMA at Local Assistance Centers over 19 days in Sylmar, Placer County, and Santa Barbara County. Forty-two complaints have been filed as a result of the 2009 wildfires. Additionally, the Division continued its efforts to help victims of the 2008 Sayre Fire by attending 2 community events, an open house, and a community meeting in Oakridge.

During 2009, the Division staff continued to work on the 2007 & 2008 fire storm complaints and related issues. To date, the Division assisted 899 consumers and recovered more than $57 Million on their behalf.

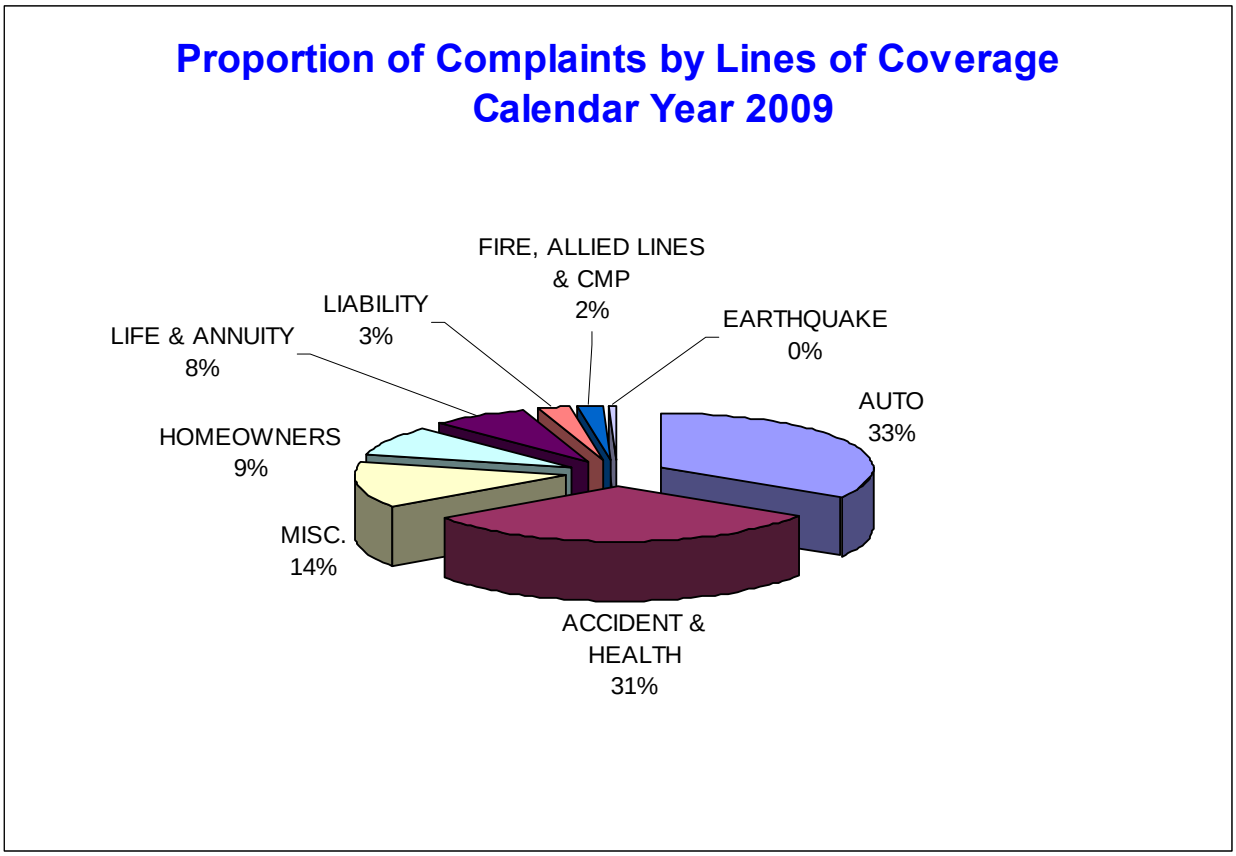
The Division will continue to assist all wildfire survivors to help effect positive resolution of their claims and related issues.

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
Auto	40.36%	40.13%	37.77%	34.43%	33.76%
Accident and Health	22.16%	25.91%	30.42%	31.76%	31.29%
Misc.	15.00%	13.93%	13.12%	12.90%	13.66%
Homeowners	9.62%	7.41%	7.16%	8.80%	8.48%
Life and Annuity	6.98%	7.23%	6.80%	7.23%	7.49%
Liability	2.85%	2.82%	2.34%	2.43%	2.54%
Fire, Allied Lines and Cmp	2.28%	1.90%	1.61%	1.82%	2.05%
Earthquake	0.26%	0.40%	0.49%	0.27%	0.43%
Null	0.48%	0.27%	0.28%	0.36%	0.31%



The graph above shows the proportion of complaints by lines of coverage for calendar year 2009.

Auto	33%
Accident & Health	31%
Miscellaneous	14%
Homeowners	9%
Life & Annuity	8%
Liability	3%
Fire, Allied Lines & CMP	2%
Earthquake	0%

Table C: Top Ten Types of Complaint Reasons (2006-2009)

Top Ten (ALL LINES) Complaint Reasons

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

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, 2009, the Mediation Program has recovered $16,665,143.78 for consumers. In accordance with CIC 10089.83, the following is a report of the results of the program for the calendar year 2009:

Table D: 2009 Residential Property, Earthquake, and Automobile Mediation Program Results

	Residential	Earthquake	Automobile	Totals
Number of mediation cases eligible	47	0	3	50
Number settled within 28 day settlement period	2	0	0	2
Number sent to mediation	14	0	2	16
Number of cases rejected by insurer	22	0	0	22
Number accepted by insurer	14	0	2	16
Number of settlements rejected within 3 day waiting period	0	0	0	0
Amount initially claimed	$2,949,583.72	0	$30,500.00	$2,980,084
Amount of settlements	$1,330,197.22	0	$22,339.00	$1,352,536.22

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.

In addition to assisting consumers with a variety of issues involving all lines of insurance except workers' compensation, CSB also participates on the Senior Issues Task Force, The Inter-agency Health Forum, and assists people impacted by wildfires and other catastrophic events at local assistance centers and work shops.

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 2009.

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 agent-brokers. RUSB works with the affected parties to clarify issues and reach a resolution. If its 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 Task Force and the Disability Advisory Committee, and assists people impacted by wildfires and other catastrophic events at local assistance centers and work shops. 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 for 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 2009

Rank	Complaint Type/Reason	# of Complaints
1	Premium & Rating / Misquotes	807
2	Coverage Question	466
3	Surcharge	315
4	Cancellation	274
5	Premium Notice/Billing Problem	267
6	Premium Refund	267
7	Nonrenewal	256

Table E: (CIC) Section 1858.35 Complaints by Type/Reason 2009 (continued)

Rank	Complaint Type/Reason	# of Complaints
8	Agent Handling	112
9	Other - Policyholder Service	66
10	Other - Underwriting	55
11	Other - Claim Handling	24
12	Misrepresentation	23
13	Policyholder Service Delays no response	22
14	Escrow Handling	22
15	Refusal to Insure	21
	All Other Reasons	149
	TOTAL	**3,146**

Table F: (CIC) Section 1858.35 Complaints by Final Disposition 2009

Rank	Final Disposition	# of Complaints	Recovery Amounts
1	Company Position Upheld	1,937	$65,379
2	Refund	223	$502,590
3	Question Of Fact	153	$17,178
4	Information Furnished/Expanded	117	$1,169
5	Premium Problem Resolved	94	$34,831
6	Advised Complainant	64	$4,537
7	Coverage Extended	57	$251,208
8	Policy Issued/Restored	56	$41,893
9	Other	52	$394
10	Underwriting Practice Resolved	48	$1,868
	All Other Disposition Codes	345	$3,289,364
	TOTAL	**3,146**	**$4,210,411**

* Recovery Amount to Consumers

CIC Section 1707.7 (d) Report

In accordance with California Insurance Code Section 1707.7(d), the Department reports there were 673 justified complaints against licensees outlined in 1707.7(b) for the year 2008, and 660 justified complaints for the year 2009.

Market Conduct Division

The Market Conduct Division (MCD) is responsible for the examination of insurance company practices on behalf of the California Insurance Department. 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. Exams are generally conducted in the insurers' offices, located nationwide. However, beginning in October of 2009, all travel was suspended due to re-allocation of the dollars initially budgeted to the MCD bureaus for travel. All exam work for the remainder of CY 2009 was required to be conducted 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 actions or enforcement actions when necessary.

The following is a summary of MCD's accomplishments for the year 2009. 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 2009

Examination Results Category	FCB	FRUB	MCD Totals
Number of Exams Adopted by the Commissioner	109	98	207
Amount of Claims Dollars Recovered or Premium Returned to Consumers	$238,829	$22,728,825	$22,957,644

Legal Actions & Penalties	FCB	FRUB	MCD Totals
No. of Actions Finalized by Legal Branch due to MCD Exam Findings	6	0	6
Penalties Resulting from Legal Branch in 2009	$2,465,000	$0	$2,465,000

FCB: Field Claims Bureau

FRUB: Field Rating & Underwriting Bureaus

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 in the Department's website. During calendar year 2009, Field Claims Bureau staff examined 4,295 claim files and cited 2,098 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 insurer rating and underwriting practices. 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 California law. FRUB examiners verify that the insurer's adopted rates have been filed and approved, and are applied consistently. This requires that underwriting be adequately documented and not unfairly discriminatory.

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 2009. The analysis of complaint data focused on the following areas: insurer, insurance line of business, and type of violation.

Complaint totals by insurer is a primary criteria for determining the Market Conduct Division's examination schedule. The ten insurers with the most closed complaints in 2009 (ranging from 2,121 at the top to 529 at number 10) have been examined in the last 3 years or will be examined in the next 2 years (4 completed, 5 in progress, 1 on schedule). Additionally, several of the insurers identified with high complaint totals are scheduled for examination more than once during the 5 year timeframe. Five of the ten 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 Department closed 38,481 complaints in 2009. The top five lines of business which generated the most complaints were the following: private passenger auto (12,830), group accident and health (7,808), individual accident and health (3,760), homeowners (2,971), individual life (2,264), and commercial auto (873). These lines of business were among the most frequently examined by both the Field Claims Bureau and the Field Rating and Underwriting

Bureau during 2009. 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. Of those 10 insurers, each has been examined within the last 3 years or is scheduled for examination by the Market Conduct Division within the next 2 years.

A geographic analysis of consumer complaints was conducted for the year 2009. 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 2010.

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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 California citizens. FSB's function 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 Troubled Companies Unit (TCU), and the Premium Tax Audit Bureau (PTAB).

FAD evaluates and monitors the financial condition of insurance companies to identify financially distressed companies and takes 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, acknowledges health insurance rates for Individual policies, ensures proper replacement of life Appointed Actuaries, verifies Individual Health loss ratio compliance, and reviews illustration certification.

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 (authorized or licensed) 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 in or 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 three bureaus: FAD-1 Bureau, FAD-2 Bureau and FAD-3 Bureau, as well as selected Division Office personnel. Following is an overview of FAD's workload statistics:

Workload Performed for the Year 2009

Financial Statements Analysis	Annual Statement	Quarterly Statement
Life and Property & Casualty	571	960
Other Entities	427	240
Surplus Lines	116	348

Corporate Affairs Applications	Number of Applications
Certificate of Authority	71
Holding Company Matters	381
All Others	171

Field Examination Division

Under the provisions of Sections 730, 733, 734.1 and 736 of the California Insurance Code, the Insurance Commissioner must 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 Association Plan of Examination. 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. In addition, FED provides financial and actuarial support to other divisions.

Various types of examinations initiated and completed by FED in 2009 are presented as follows:

Type of Examinations	Initiated	Completed
Domestic Companies	46	46
Underwritten Title Companies	6	8
Foreign Companies	5	4
Qualifying Exams	1	1
Statutory Exams	0	1
Total:	58	60

Actuarial Office

The AO provides technical assistance within the FSB. 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; reviews and acknowledges Medicare supplement and other accident & health insurance rate filings; and ensures compliance regarding Appointed Actuary changes, Individual Health loss ratios, and illustration certification. Listed below are workload statistics of the AO:

Actuarial Reviews	Number Reviewed
Reinsurance Treaties	8
Health Rate Filings	234
Credit Insurance Rate and Deviation Filings	120
Actuarial Memorandum	97
Life Insurance and Annuity Policy Forms	927
Asset Adequacy Issues Summaries	450

Troubled Companies Unit

Staffed by three seasoned analysts, TCU is responsible for overseeing those insurers identified in the CDI's Early Warning System as being financially troubled. Whereas the number of companies under review does vary, as does the level of complexity each presents, an average of 45 companies are assigned to the TCU at any given time.

TCU personnel carefully monitor the financial status of assigned companies and make 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 2009 on business done during 2008, other than retaliatory and surplus line taxes, amounted to $1,949,094,088. Refunds of $103,988,983 were granted during the year.

Additional assessments proposed by the Insurance Commissioner to the Board of Equalization and the State Controller's Office totaled $16,870,220.

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 2009 on business done during 2008 totaled $2,746,316.

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 2009 for calendar year 2008 totaled $148,485,994.

2009 ANNUAL REPORT

ENFORCEMENT BRANCH

ENFORCEMENT BRANCH ANNUAL REPORT INSURANCE CODE SECTIONS 1872.9, 1872.96, 1874.8 FISCAL YEAR 2008-09

The Enforcement Branch provides its portion of the Annual Report of the Insurance Commissioner. The following information represents a synopsis of the Enforcement Branch, which includes Division responsibility, program oversight, expenditures, and activities for Fiscal Year 2008-09. The Enforcement Branch also provides this information to meet the requirements of Sections 1872.9, 1872.96 and 1874.8 of the California Insurance Code.

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, one CEA II (Investigation Division), three Bureau Chiefs (Fraud Division), one Supervising Fraud Investigator II, hereafter referred to as Captain, (Fraud Division), one Staff Services Manager II, hereafter referred to as Administrative Chief, (Branch Headquarters), and an Executive Assistant.

Branch Headquarters – The Administrative Chief, is responsible for the operation of the Branch Headquarters Office in support of 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.

Internal Affairs/Backgrounds – A Captain oversees all internal affairs investigations for the Department and pre-employment background investigations for the Branch.

Computer Forensic Team – The Supervising Fraud Investigator I, hereafter referred to as a Detective Sergeant, coordinates the efforts of the Computer Forensic Team that supports statewide investigative efforts through technical expert forensic examinations of computer data seized during investigations.

Enforcement Tactics and Training Unit – The Supervising Fraud Investigator I, hereafter referred to as a Detective Sergeant, coordinates the efforts of training, weapons management, and range masters in the Enforcement Tactics and Training Unit to all sworn staff.

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 investigate complaints and reports of suspected violations of the California Insurance Code and other laws and regulations pertaining to the business of insurance, and to seek the appropriate enforcement action (administrative, criminal or civil) 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 charged the Investigation Division with the responsibility and authority to take steps to protect California policyholders from insurance related crimes committed by businesses and individuals.

The public and the insurance industry are both safeguarded when the Investigation Division investigates crimes and violations and seeks criminal prosecutions and disciplinary actions where warranted by the evidence. In this way, those who break the law can be disciplined or removed from the industry when warranted and future crimes and violations are deterred.

The Insurance Commissioner has established case handling priorities for the Investigation Division, which includes premium theft, senior citizen abuse, bogus insurance companies, and deceptive sales practices by insurance companies, consumer abuse by automobile insurance agents and companies, title insurance rebates, and consumer abuse by public adjusters, and bail agents.

BUDGET AND STAFFING

During the Fiscal Year 2008-09, the Investigation Division's expenditures totaled $9,395,631.51 in support of an authorized staff of 89 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 state-wide 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. The Chief of Enforcement Branch Headquarters provides administrative support to the Regional Offices and is responsible for division

intake and inquiries, equipment, human resource functions, training unit, statistical analysis and E-government systems.

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 – 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. In April 2007, the Department established a sworn peace officer unit within the Division. The Criminal Operations Point of Sale Unit's primary objective is to protect the public by conducting efficient and effective criminal investigations, effect arrests, execute search warrants, liaison with allied law enforcement and advance the Department's continuing goal of protecting consumers using its full peace officers powers as set for in Penal Code 830.3.

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

- Premium Theft

  Identified by the Investigation Division staff as the single most prevalent type of misconduct seen in the insurer producer area. Instances can range from a single theft of minimal amounts to multi-million dollar scams causing the insurance industry and competitive businesses to become the unwitting victims of financial loss.

- Senior Citizen Abuse

  Particular agents and insurers target their marketing efforts to senior citizens. Certain agents and insurers abuse the senior citizen customer by over selling, misrepresentation, and selling unneeded or even inappropriate insurance products to them. At times, the misconduct is criminal, involving theft, false documents, and confidence games. The latest abuse violations involve life insurance and annuity sales and Medicare Advantage Plan and Medicare Prescription Drug Plan marketing misrepresentations.

- Insurance Company Deceptive Practices/Condoning Sales Force Misconduct

Insurers may fail to properly monitor and control their sales forces, in part, because they are seen as independent contractors. The failure, in extreme cases, may involve ignoring complaints and other evidence of sales force misconduct or even training and encouraging misconduct.

- Phony Insurance Companies

  This type of fraud involves selling falsified papers that appear to be insurance policies or contracts. This 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.

- Public Adjuster Misconduct

  Public adjusters can represent insurance claimants in conflict with their insurance companies. This specialty has, in the past, had a high incidence of contested practices, including high-pressure sales, overcharging, conflict of interest with vendors, and failure to account for claims proceeds.

- Title Company Bribery and Kick-Back Activity

  These matters represent problems associated with a remote purchaser of insurance. The title insurer sells a policy needed for closing a real estate transaction. The property buyer pays for it, but the realtor selects the insurer. The problem is that the title companies and their representatives engage in kickbacks and commercial bribery to induce business from the realtors. This adds to the cost, but not the commercial value of the insurance.

- Bail Agent Activity

  A bail agent is a person permitted to solicit, negotiate, and transact undertakings of bail on behalf of any pointed surety insurer. An unscrupulous bail agent may fail to return collateral, aid and abet unlicensed bail agents and fail to remit premium to insurer.

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

DIVISION WIDE INVESTIGATIONS

During Fiscal Year 2008-09, 1,742 complaints were received from consumers, other CDI units, law enforcement and from other agencies. In addition, hundreds of inquiries about individuals and entities transacting insurance were processed.

This resulted in cases being opened during the fiscal year involving 884 different individuals and/or entities.

- 410 additional complaints within existing cases were consolidated.

- Cases opened against 899 different individuals and/or entities were completed during Fiscal year 2008-09.

874 Cases were still in progress as of June 30, 2009.

(Criminal Cases..... 476)
(Regulatory/Administrative Cases... 398)

263 Reports of Suspected Violation[1] were pending as of June 30, 2009.

(Criminal Cases..... 63)
(Regulatory/Administrative Cases... 200)

During Fiscal Year 2008-09, the Investigation Division has identified and reported chargeable fraud of $9,953,246, ordered restitution of $12,507,340, investigative cost recoveries of $111,860 and fines and penalties of $2,783.583.

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

CRIMINAL PROSECUTION CASES

Referral to Prosecutors..... 79
Case Filed by Prosecutors..... 51
Search Warrants Obtained 35
Arrest Warrants Obtained..... 35
Arrested..... 34
Convictions..... 33

REGULATORY PROSECUTION CASES

Cases Referred for Regulatory Prosecution 148

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

Effective July 1, 2000 and as amended in 2005, the Investigation Division, Legal Division and Consumer Services and Market Conduct Branch were charged with implementing Senate Bill 940 (Chapter 884, Statutes of 1999) and Assembly Bill 1183 (Chapter 717, Statutes of 2005). These bills, which established and amended Insurance Code Section 1872.81 of the Insurance Code, require each insurer doing business in California to pay to the Insurance Commissioner an annual fee of thirty-cents for each insured vehicle under an insurance policy it issues in the state. This section limits the expenditure of this revenue to maintaining and improving consumer service functions of the department that are related to automobile insurance.

AUTO INSURANCE INVESTIGATIONS[2]

Opened:..... 175

Completed: 163

In progress as of June 30, 2009 213

Reports of Suspected Violation 42

[2] *This 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 third year of grant funding, the Life and Annuity Consumer Protection Program provided $942,996 in grants funds to ten 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 their transaction of life insurance and annuities with California consumers.

LIFE INSURANCE AND ANNUITY PRODUCTS INVESTIGATIONS[3]

Opened:..... 183

Completed: 175

In progress as of June 30, 2008: 191

Reports of Suspected Violation: 67

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

INITIATIVES TO REDUCE PRODUCER FRAUD:

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

- Expansion of the Criminal Operations Point of Sale Unit with the ultimate objective of transitioning all Division investigator positions to peace officer status.
- Established quality control measures at the regional level to ensure compliance of Division policies designed to improve efficiency and increase productivity.
- 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.

- In conjunction with CDI's 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.
- Improving 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.
- Providing Life and Annuity Consumer Protection Program (LACPP) training to County Prosecutors, local law enforcement agencies and consumer groups
- Developing legislative proposals to strengthen laws governing the transaction of insurance and the enforcement of those laws.
- Continuing outreach to industry associations, consumer groups and allied law enforcement agencies.

During Fiscal Year 2008-09, the Investigation Division has strived to continue providing the best consumer protection investigative services in the nation as demonstrated by the numerous enforcement actions; both criminal and administrative, taken against insurance code violators.

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 from economic loss and distress by actively investigating and arresting those who commit insurance fraud and to reduce the overall incidence of insurance fraud through anti-fraud outreach to the public, private and governmental sectors."

BUDGET AND STAFFING

Fiscal Year 2008-09 Fraud Division Budgeted/Revenue/Expenditures by Program and Fiscal Year Staffing level:

Fraud Auto Revenues: [4].....$37,504,207

Insurance Fraud Assessment, Auto
- Budgeted Levels:.....$40,431,238
- District Attorneys' Auto Distribution: $18,835,756
- State Operations Auto Expenditures: $19,765,586

Insurance Fraud Assessment, Workers' Compensation
- Budgeted Levels:.....$49,506,181
- District Attorneys' Workers' Compensation Distribution:.....$28,844,903
- State Operations Workers' Compensation Expenditures:.....$20,267.865

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

Insurance Fraud Assessment, Disability and Healthcare
Budgeted Levels:.....$3,565,260
District Attorneys' Disability and Healthcare Distribution: $1,712,000
State Operations Disability and Healthcare Expenditures: $2,210,487

Insurance Fraud Assessment, General
Budgeted Levels:.....$2,390,306
State Operations General Assessment Expenditures:.....$3,192,955
Fiscal Year 2008-09 Fraud Division Positions[5]:.....289.0

[5] *Includes all authorized program 20 positions.*

FRAUD DIVISION (ADMINISTRATION AND OPERATIONS)

The Fraud Division has 10 regional offices serving all 58 counties. The Enforcement Branch Headquarters office 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.

Enforcement Branch Headquarters has eight major sub-units performing the following: activities in support of Fraud Division: receiving, cataloging, and processing Suspected Fraudulent Claims (SFC); processing seized computer evidence; auditing insurance companies' Special Investigative Units for compliance with applicable laws and regulations; providing grant funding to participating district attorneys; auditing grant funds awarded to district attorneys; collecting and analyzing Fraud Division statistical data; and training Fraud Division employees.

AUTOMOBILE INSURANCE FRAUD

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

Fraud Division Detectives primarily enforce the provisions of California Penal Code Sections 548 – 550, and the provisions of California Insurance Code Section 1871.4. Criminal investigations 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.

During Fiscal Year 2008-09, the Fraud Division received 14,312 suspected fraudulent claims (SFCs), assigned 513 new cases and made 272 arrests. Detectives completed investigations and submitted 282 cases to prosecuting authorities. The potential loss amounted to $219,941,105.

District Attorneys' Automobile Insurance Fraud Program

During Fiscal Year 2008-09, 38 counties received funding totaling $13,051,000 through

the Department's Auto Insurance Grant Program. The amount of financial support funded to each county is determined based on three components: county population, the number of SFCs reported, and a plan to utilize the grant funding.

For Fiscal Year 2008-09, the district attorneys initiated 2,115 investigations and made 955 arrests, culminating in 826 convictions. This number includes enforcement actions by both Fraud Division and local law enforcement.

Chargeable fraud amounted to $11,350,631, with $2,061,227 in restitution ordered by the courts.

ORGANIZED AUTOMOBILE FRAUD ACTIVITY INTERDICTION

The California State Legislature recognized 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. Only a focused, coordinated effort by all appropriate agencies and organizations can effectively deal with this problem.

With the passage of Assembly Bill 1050 (Wright), the Organized Automobile Fraud Activity Interdiction ("Urban Grant") Program was created in Fiscal Year 2000-01. California Insurance Code Section 1874.8 mandates that 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 collisions and the filing of fraudulent automobile insurance 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 2008-09, the Fraud Division assigned 268 new cases and made 263 arrests with 310 submissions to prosecuting authorities. Potential Loss amounted to $11,981,029.

District Attorneys' Organized Automobile Fraud Activity Interdiction Program

During Fiscal Year 2008-09, nine counties were awarded grant funding totaling $5,784,756. The grant-awarded district attorneys reported 293 arrests, including arrests made by Fraud Division. District attorneys prosecuted 321 cases involving 652 defendants with chargeable fraud totaling $8,068,122. The prosecution of District Attorney cases resulted in 241 convictions.

DISABILITY AND HEALTHCARE FRAUD

According to Section 1871(h) of the California Insurance Code, health insurance fraud is a particular problem for health insurance policyholders. Although there are no precise figures, it is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily.

As mandated by California Insurance Code Section 1872.85, funding for the Disability and Healthcare Fraud Program is derived from an annual assessment of 10 cents annually for each insured under an individual or group insurance policy issued in the state. This funding supports criminal investigations 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 (Usually Associated with Medically Unnecessary Surgery Claims)
- Durable Medical Equipment
- Posed as Another to Obtain Benefits

This program began as a task force during the fiscal year 2004-05, concentrating their efforts in Los Angeles and Orange Counties. Currently, there are nine Detectives and two Detective Sergeants statewide who investigate and arrest suspected violators. This team also provides assistance and training to investigators and adjusters of private health insurance companies, other state and federal government agencies, and allied law enforcement agencies.

During Fiscal Year 2008-09, the Fraud Division identified and reported 474 SFCs, assigned 62 new cases and made 11 arrests with 12 submissions to prosecuting authorities. Potential Loss amounted to $26,344,298.

District Attorneys' Disability and Healthcare Program

In Fiscal Year 2008-09, five counties received funding totaling $1,702,400 through the Department's Disability and Healthcare Insurance Fraud Grant Program. The district attorneys reported 198 investigations, 56 arrests, and 49 convictions, which also included a majority of Fraud Division arrests. Chargeable fraud amounted to $223,629,474, with $2,383,403 in restitution ordered by the courts.

WORKERS' COMPENSATION

During the 1920s, most states, including California, accepted a new social insurance program known as workers' compensation. In California, workers' compensation insurance is a no-fault system. Injured employees need not prove the injury was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury. The National Insurance Crime Bureau estimated in the year 2000, workers' compensation insurance fraud was the fastest-growing insurance scam in the nation, costing the industry $5 billion per year by what many people consider a victimless crime. Often white-collar criminals, including doctors and lawyers, dupe 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 2008-09 is $48,136,818

During Fiscal Year 2008-09, the Fraud Division identified and reported 5,174 SFCs, assigned 539 new cases, made 218 arrests and referred 327 submissions to prosecuting authorities. Potential Loss amounted to $205,811,250.

The investigation of Workers' Compensation Fraud very often involves difficult and lengthy investigations. These investigations have resulted in convictions and the reduction of a number of medical and/or legal workers' compensation mills. Since Fiscal Year 2003-04, the CDI has participated as a member of the "Underground Economy Strike Force," per Assembly Bill 202. The Fraud Division continues to focus its efforts in that area of the Underground Economy known as employer misrepresentation or Premium Fraud. Participation on the Strike Force helps the Fraud Division and district attorneys investigate and prosecute the premium fraud cases which most significantly impact the California economy and business climate.

Evidence suggests that the aggressive anti-fraud campaign by the Department, the district attorneys, the insurance industry and California employers continues to play a substantial role in reducing crime and helps lower workers' compensation premiums for employers statewide.

District Attorneys' Workers' Compensation Program

In Fiscal Year 2008-09, the district attorneys reported a total of 560 arrests, which also included the majority of Fraud Division arrests. During the same time frame, district attorneys prosecuted 1,090 cases with 1,221 suspects, resulting in 555 convictions. Restitution of $23,767,448 was ordered in connection with these convictions and $5,282,203 was collected during Fiscal Year 2008-09. The total chargeable fraud was $312,004,714 representing only a small portion of actual fraud since many fraudulent activities had not been identified or investigated.

PROPERTY, LIFE AND CASUALTY FRAUD

The Property, Life and Casualty 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 for approximately 5 percent of the Fraud Division's allocated budgetary resources. The funding stream for this program is generated from a $5,100 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 2008-09, the Fraud Division received 6,489 SFCs, assigned 114 new cases, made 42 arrests and referred 38 submissions to prosecuting authorities. Potential Loss amounted to $504,315,606.

SPECIAL INVESTIGATIVE UNIT – COMPLIANCE REVIEW OFFICE

The primary responsibility of the Fraud Division, 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 approximately 1,200 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 2008-09, the SIU Compliance Review Office audit staff conducted 11 on-site audits of primary insurance companies which included 35 subsidiary companies,

for a total of 46 insurers. Of the 46 companies reviewed, 11 were authorized to write and are currently writing workers' compensation insurance in California. Six of the 11 primary companies reviewed were out of state, while the review of one of one company included on-site audits at several locations in California and out of state.

The purpose of SIU compliance reviews is to identify areas of regulatory non-compliance or operational weaknesses of an insurer's SIU and provide recommendations for improvement. The compliance auditors also provide technical assistance to the insurer's SIU management.

Common findings of SIU compliance reviews include:

- SIU inadequate or non-existent;
- Suspected fraud not reported to District Attorneys, CDI ;
- Fraud referrals (FD-1s) contain errors/omissions;
- Fraud referrals submitted on outdated forms (FD-1's);
- Written anti-fraud procedures inadequate;
- SIU investigation procedures inadequate or non-existent;
- Continuing training not received by SIU;
- Anti-fraud training not provided by SIU;
- Training records incomplete or non-existent;
- Annual compliance report delinquent;
- Annual compliance report inaccurate or incomplete; and,
- TPAs, contracted SIU's not monitored by insurer

Once an SIU compliance review is completed, a preliminary report (or Exit Review Report) is issued to the company identifying proposed findings and recommendations. The insurer is given 30 days to respond and provide supporting documents and information, after which a Final Report of Findings (final report) is issued to the insurer. The final report may show that all findings have been resolved and the company is in compliance with the SIU regulations, or that all or some of the findings still stand and the insurer is subject to legal action including fines/penalties. If a company is audited and is in full compliance, there are no findings and no preliminary report is necessary; the company will be issued a final report indicating that there are no findings.

The SIU Compliance Office expanded the scope of its audits to include examinations of policy files and premium audit results when conducting SIU compliance reviews at companies which write workers' compensation insurance in California. This will provide for the identification of policies that may contain evidence of possible suspected insurance fraud, which may have warranted referral to and investigation by the insurer's SIU. The procedures will also identify cases which should have been referred to district attorneys and the CDI Fraud Division.

FRAUD GRANT AUDIT UNIT

The primary responsibility of the Fraud Division, 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.

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. If a district attorney's office has more than one type of insurance fraud program, the programs are audited concurrently to maximize efficiency.

In Fiscal Year 2008-09, the FGAU completed fiscal audits of 15 district attorney's offices; a total of 64 grants were audited (Workers' Compensation-26, Automobile-27, Organized Automobile-8, Disability and Healthcare-2, Life and Annuity-1).

Common findings are indicated below:

- Expenditure report not submitted or not submitted timely
- Independent financial audit report not submitted timely
- Inadequate documentation of salaries and benefits
- Inaccurate closed case log

After the FGAU completes its analysis, a preliminary report is issued to the district attorney's office, and there is 30 days to respond and provide additional information. Subsequently, a final report is issued to the district attorney's office, CDI Enforcement Branch Deputy Commissioner, Division Chief, Bureau Chief, Regional Office Captain, Legal Division, Enforcement Branch Headquarters Chief, and Program Manager. Audit findings may impact future grant funding.

ANTI-FRAUD OUTREACH

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

Internet

The CDI Internet public website contains information on the following subjects: Insurance Fraud Reporting Forms; What is Insurance Fraud; Where to Report; Fraud Division Regional Offices; Workers' Compensation Fraud Conviction Data; Automobile

Fraud; Property, Life and Casualty; Health and Disability; Workers' Compensation Fraud; Insurer Special Investigative Units; and Fraud Newsletters.

- **Posting Convictions on Web Site** – Consistent with the requirements of AB 2866, which went into effect January 1, 2005, the Department continues to post 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, the following information concerning convictions in workers' compensation insurance fraud cases:
  - the name, case number, county or court, and other identifying information with respect to the case
  - the full name of the defendant
  - the city and county of the defendant's last known residence or business address
  - the date of conviction
  - a description of the offense
  - the amount of money alleged to have been defrauded; and
  - a description of the punishment imposed, including the length of any sentence of imprisonment and the amount of any fine imposed

Community Forums

The Fraud Division participates in community-sponsored events, such as town hall meetings, public hearings, and underground economy seminars. These forums give the Division 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 Fraud Division participates with local, state, and national broadcasting outlets to educate the public about insurance fraud in California. One example is the workers' compensation medical provider video produced by the Employer Fraud Task Force.

Industry Liaison

The Fraud Division 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 Division maintains a routine and specific liaison with the following State agencies or entities on matters of overlapping jurisdiction or mutual concern: California Peace Officer's 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 Rehabilitation and Corrections; Department of Alcoholic Beverage Control; and Regional Auto Theft Task Forces.

Public Awareness

Our goal is through public awareness to advance communications to help consumers understand insurance fraud and to create stronger deterrence.

THE NUMBER OF CASES REPORTED TO THE FRAUD DIVISION

The source of leads for investigations initiated by the Fraud Division is the Suspected Fraudulent Claim (SFC), also known as a 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. All referrals submitted to the Fraud Division, regardless of the reporting party and supporting evidentiary information, are assigned a case tracking number, placed in the Fraud Integrated Database (FIDB), and forwarded to supervisors in the regional office with jurisdiction over the allegations. The Fraud Division, like all other law enforcement agencies, must track and make a determination on whether further action, if any, is to be taken on all reports filed under its mandate. All reports will be reviewed, although the majority will not be assigned for further investigation.

During Fiscal Year 2008-09, Fraud Division received the following number of Suspected Fraudulent Claims (SFCs) by program:

Auto and Urban Auto	14,312
Property Casualty	6,489
Workers' Compensation	5,174
Health	474
Total	**26,449**

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

SFCs unassigned due to insufficient evidence:	16,020
SFCs unassigned due to other reasons:	9,364

SUSPECTED FRAUDULENT CLAIM INTAKE OVERVIEW

The vast majority of SFCs are generated by the insurance industry. The standard for referring an SFC is codified by a number of statutes within the Insurance Code. The fact that there are five different statutes offering various standards for when to refer, often results in referrals that fail to rise to the level necessary to result in a criminal conviction. The variations in the Insurance Code for the standard to refer range from when the carrier "believes" or has "reason to believe" to "has reason to suspect" that insurance fraud has occurred. As a result, different interpretations have demonstrated inconsistencies regarding the referral process. Some SFCs make allegations of abuse, which does not rise to the level of fraud. It should also be pointed out that the referrals submitted by the insurance industry contain errors and misinformation.

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; and
- Insufficient resources, the statute of limitations, discussion with a district attorney regarding facts of the SFC resulted in rejection, or referral to another agency.

THE NUMBER AND KIND OF CASES PROSECUTED AS A RESULT OF FUNDING RECEIVED UNDER INSURANCE CODE §1872.7

Insurance Code Section 1872.7 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) 271

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.

Fraud Area	Amount Paid[1]	Suspected Fraudulent Loss[2]	Potential Loss[3]
Automobile	$20,361,094	$41,259,805	$219,941,011
"Urban Auto"	$1,744,751	$3,510,575	$11,981,029
Health	$9,356,858	$17,548,390	$26,344,298
Property Casualty	$41,301,783	$58,560,069	$504,315,606
Workers' Compensation	$120,459,637	$86,062,068	$205,811,250
TOTALS	**$193,224,123**	**$206,940,907**	**$968,393,194**

[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

To reduce insurance fraud, the Department continues to implement the following:

- A systematic effort to measure the extent and nature of fraud in the system and the types of fraudulent activities most responsible for driving up the insurance premium.
- An overall strategy for combating fraud based on goals, objectives, priorities and measurable targets.
- A means to periodically evaluate the effectiveness of the efforts to reduce the occurrence of those types of fraud.

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 REDUCTION OF FRAUDULENT DENIALS AND PAYMENTS OF COMPENSATION, PURSUANT TO INSURANCE CODE §1871.4

Fraud Area	Restitution Ordered	Restitution Collected
Automobile	$2,061,227	$392,423
"Urban Auto"	$1,129,123	$435,130
Health	$2,383,403	$7,103,336
Workers' Compensation	$23,767,448	$5,282,203

THE NUMBER AND TYPES OF CASES INVESTIGATED AND PROSECUTED WITH FUNDS SPECIFIED INSURANCE CODE §1872.8

Workers' compensation fraud is committed to obtain workers' compensation benefits to which a claimant is not entitled. Suspects make false statements to doctors, employers, and insurance carriers regarding work-related injuries, work while receiving benefits, and fake injuries.

Caseload (open and newly assigned cases): 1,319

Arrests: 218

WORKERS' COMPENSATION INSURANCE ANTI-FRAUD PROGRAM

District Attorney Online Program Report (DAR)

In mid 2006, the Fraud Division implemented a web-based (online) District Attorney Program Report, which enables the electronic submission of the Bi-Annual Workers' Compensation Program Report. District attorneys are now able to enter data via the web, resulting in consistent and timely reporting; updating of past year(s) statistics; and real-time trend analysis. This program will reduce report-processing time for both the Fraud Division and district attorneys. The development of the electronic DAR was achieved in partnership with the Fraud Division, district attorneys, and the Fraud Assessment Commission (FAC).

For Fiscal Year 2008-09, the DAR maintains webpage that allows district attorneys to download the Request for Application (RFA) and other important program materials and information for the Workers' Compensation Insurance Fraud Program. The Fraud Division's goal was to provide the district attorneys easy access to our materials and allow the ability to save the RFA and attachments to their computer hard drives.

Fiscal Year 2009-10 Budget (Local Assistance)

On September 16, 2008, the FAC voted to increase district attorney grant funding (Fiscal Year 2009-10) by $1,127,500, thereby increasing the total amount to $30,227,500, which included $300,000 for a specific focus on computer forensics or computer software that would assist district attorneys with the collection and analysis of evidence. Counties would apply for these funds during the normal funding application process by including a line item(s) in their proposed budget indicating the type of equipment/software to be purchased, the cost, and a brief description of how the purchase will enhance the collection and analysis of evidence.

A funding increase requires the department to prepare a justification (budget change proposal) for the budget and submit it to the Legislature for analysis. Additionally, the Legislative Analyst's Office (LAO) looks at the budget request along with the Department of Finance (Governor's Office).

Request for Application (RFA)

With the Fiscal Year 2009-10 application cycle, suggestions provided by participating counties were incorporated to make a more efficient and concise RFA. Questions in the County Plan section were reevaluated and restructured to eliminate duplication and better organize the document as a whole.

Implementation of Research on Workers' Compensation Medical Payment Accuracy Study and Fraud in Workers' Compensation Payroll Reporting

Over the years, the Department of Insurance, in conjunction with the Fraud Assessment Commission has attempted to measure the amount of fraud in California's workers' compensation system. The goal of this measurement is quantifying the magnitude of California's problem in order to determine the appropriate allocation of resources via an established, coordinated statewide effort, and to ascertain the success of these efforts. In fiscal year 2007-08, the Department had contracted with the Regents of the

University of California through University of California at Berkeley to conduct an extension of a research that was previously funded by the California Commission on Health and Safety and Workers' Compensation. The research titled "The Fraud in Workers' Compensation Payroll Reporting Study" analyzed the degree to which employers' under-report or misreport payroll for workers' compensation insurance purposes. The research study was presented to the Commission in January 2009. The study had examined data from the period of 1997 to 2005. The report concluded that in the year 2005 alone, under-reported insurance premiums ranged from $2.09 billion to $2.87 billion. Furthermore, the report indicates that several high-risk employers have fraudulently misreported their workers in high-risk/high-premium classes as earning wages in lower-risk occupations, accounting as much as 40-60% of payroll.

Fiscal Year 2008-09 Fraud Division's Strategic Plan

The goal of the Fraud Division is to produce quality and cost-effective investigations, which result in successful enforcement actions. There are four critical elements required to achieve successful outcomes: an aggressive outreach program, partnership with key stakeholders, effective trend analysis, and a balanced caseload. Past successful outcomes 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 and 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 of criminals have been accomplished by civil actions. A single victim, collective group of individuals, or an insurance carrier has followed up with civil actions, which have terminated the criminal enterprise and provided civil fines and restitution. Additionally, the Fraud Division has worked closely with district attorneys on investigations involving unfair business practices and related actions.
- Investigative Inquiry: Potential fraud activity or abuse have been stopped and deterred by an 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 prevents escalation to the level of a full criminal investigation.

During Fiscal Year 2008-09, the Fraud Division received 5,174 Suspected Fraudulent Claims (SFC) for the workers' compensation program. The reported losses[6] entered on the completed SFCs were as follows: $177,024,714 - Potential Loss, $81,506,498 - Suspected Fraud, $116,734,373 - Actual Paid, and $12,548,073 - Premium Fraud Loss.

There were 539 new cases assigned to Fraud Division investigative staff, bringing the overall total caseload to 1,317 for the fiscal year. The Fraud Division Detectives and allied agencies executed 41 search warrants resulting in 250 workers' compensation cases submitted for prosecution. There were 218 suspects arrested and 156 defendants were convicted.

[6] *As defined in the Fraud Division's FD-1 Instruction Manual, Potential Loss is the dollar loss/exposure for the claim if the fraud had gone undiscovered. Suspected Fraud is defined as that amount of the Actual Paid suspected to be fraudulent. Actual Paid is defined as the total dollar amount on the claim of the referral date. Premium Fraud is defined as actual or potential loss of premium dollars paid by employers.*

Objective: Reduce Incidents of Employer Misrepresentation (433 cases investigated)

As highlighted in our significant cases, the Fraud Division continues to coordinate and participate in actions to confront the issues of workers' compensation employment misrepresentation through on-going participation in joint activities with allied state, county, and local agencies including the Underground Economy Task Force and the Premium Fraud Task Force.

As the result of a Memorandum of Understanding (MOU) with the Employment Development Department (EDD) Tax Audit Branch, quarterly reports of employers who are assessed additional taxes following an audit and who have fines imposed are forwarded to the Fraud Division.

In addition, the Fraud Division obtains information from the Workers' Compensation Insurance Rating Bureau (WCIRB) such as employers' history of insurance policies, the identity of carriers, audit, and rating information, and data on cancelled policies. This information proves vital during investigations.

Objective: Reduce Incidents of Medical Provider Fraud (64 cases investigated)

The fraudulent billing for medical expenses continues to be a significant cost driver in the workers' compensation system. The Fraud Division knows from experience that the successful prosecution of a medical provider for insurance fraud, although labor intensive, serves as a strong deterrent to those already committing insurance fraud or those individuals thinking about committing fraud.

A research study, commissioned by the FAC, to determine the extent of medical overpayments and underpayments, was completed in June 2008. The results of this study, the first to measure medical payment accuracy in California, quantifies what the experts in workers' compensation fraud detection have known for some time: medical provider fraud is one of the primary cost drivers that inflate the cost of claims and insurance premiums. That is why this area of workers' compensation insurance fraud has been given one of the highest priorities in Fraud Division investigations.

Objective: Reduce Incidents of Employers Defrauding Employees (37 cases investigated)

The Fraud Division regularly participates in sweeps with the Division of Labor Standards Enforcement (DLSE) and the Contractors State Licensing Board (CSLB). These sweeps have resulted in identifying numerous employers in violation of Labor Code Section 3700.5, as well as providing leads for premium fraud investigations.

Objective: Commissioner's Advisory Task Force on Insurance Fraud

Insurance Commissioner Steve Poizner convened an Advisory Task Force on Insurance Fraud (Task Force) to address major issues relating to insurance fraud. The Task Force completed a comprehensive review of the anti-fraud insurance programs and identified 18 recommendations to consider in reducing insurance fraud in California. The recommendations are consolidated into the following five categories identified by the Task Force.

- Organization and Efficiency of the CDI Fraud Division

- Industry Role in Fighting Fraud
- Public Role in Fighting Fraud
- Fraud Statutes and Regulations
- Technologies

The Fraud Division is currently implementing the following recommendations:

- Placing personnel in existing fusion centers within the State so law enforcement can share information more efficiently and quickly identify emerging trends and crime patterns.
- Developing and providing better training for the Special Investigation units (SIU) on the recognition, documentation, and reporting of suspected insurance fraud claims.
- Recognizing insurance companies that go beyond compliance for their greater commitment to fighting fraud.
- Increasing the outreach efforts of CDI about the consequences of fraud, how the public can recognize it and report it.

Objective: Continue to Maintain 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 2008-2009

Fraud Activity Type	Total Caseload
Claimant Fraud	668
Insider Fraud	12
Employer Defrauding Employee	37
Legal Provider	6
Medical Provider	63
Misclassification	39
Other Workers' Compensation	57
Pharmacy	1
Under Reported Wages	140
Uninsured Employer	288
X-Mod Evasion	6
Grand Total	**1,317**

Outreach

One component of the Fraud Division's mission statement is to provide anti-fraud outreach and training to the public, private, and governmental sectors. During the past fiscal year, outreach was provided by each of the nine regional offices, as well as by headquarters office staff, to a variety of entities from the public, private, and governmental sectors.

Public Outreach

- **Posting Convictions on Web Site** – Consistent with the requirements of AB 2866, which went into effect January 1, 2005, the Department continues to post 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, the following information concerning convictions in workers' compensation insurance fraud cases:
  - the name, case number, county or court, and other identifying information with respect to the case
  - the full name of the defendant
  - the city and county of the defendant's last known residence or business address
  - the date of conviction
  - a description of the offense
  - the amount of money alleged to have been defrauded; and
  - a description of the punishment imposed, including the length of any sentence of imprisonment and the amount of any fine imposed

- **Community Forums/Town Hall Meetings** – The Fraud Division participates in community-sponsored events, such as town hall meetings, public hearings, and underground economy seminars. These forums give the Fraud Division 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 Fraud Division participates with local, state, and national broadcasting outlets to educate the public about insurance fraud in California. One example is the video, "Workers' Compensation: Employee Rights & Responsibilities" produced by the Employers' Fraud Task Force.

Another example was a one-hour documentary that aired on MSNBC Cable titled, "MSNBC Undercover: Home Wreckers." The show highlighted undercover operations to combat unlicensed building contractors, revealed the steps involved in conducting an undercover sting operation, and how consumers do not realize the risks they take when they hire an unlicensed contractor for home improvement work. The undercover operations detailed in the show were conducted by the California Contractors State

License Board's Statewide Investigative Fraud Team (SWIFT), which includes the participation of Fraud Division Detectives.

July 2008

- Employer Fraud Task Force – Inland Empire
- Fraud Awareness Event – Yolo County

August 2008

- Employer Fraud Task Force – Los Angeles County

September 2008

- San Jose State University
- California Insurance Auditors and Managers Association Premium Fraud Presentation

October 2008

- California State University, Fresno - Criminology Advisory Group
- California State University, Sacramento – Career Day
- Westwood College Los Angeles – Recruitment Presentation
- CDAA Conference Premium Fraud Audit Presentation

December 2008

- California State University, Sacramento – Career Day

February 2009

- South Orange Community College District

May 2009

- Pacific Association of Building Service Contractors – Premium and Provider Fraud Presentation
- Imperial County Chamber of Commerce Fraud Awareness Fair
- Workers' Compensation Insurance Organizations (WCIO) - Benicia

Private Outreach

The Fraud Division also does joint training sessions with local law enforcement for SIUs throughout the State. The following includes, but is not limited to, joint outreach sessions with local law enforcement:

July 2008

- CDI/NICB/SIU Roundtable Meeting in Fresno

August 2008

- SIU Sedgwick Insurance
- Workers' Compensation Fraud presentation to SCIF in Solano County

- SIU Safeway
- Workers' Compensation Fraud presentation to SCIF in Los Angeles County
- SIU SCIF in Orange County
- Workers' Compensation Fraud presentation to Professionals in Workers' Compensation (PWC) in Fresno County

September 2008

- Association of Workers' Compensation Professionals in Sacramento County
- Travelers Insurance Fraud Awareness Day
- SIU Liberty Mutual
- SIU SCIF in Sacramento County
- Athens Group Workers' Compensation Fraud Presentation

October 2008

- ICW Group Insurance Services Premium Fraud Presentation - Valencia
- SIU Comp West Premium Fraud Red Flag Training

November 2008

- ICW Group Insurance Services Presentation – San Diego
- American All-Risk Loss Administrators Presentation
- ICW Group Insurance Services Premium Fraud Presentation – Sacramento County
- ICW Group Insurance Services Presentation – San Francisco
- SIU Liberty Mutual

December 2008

- SIU Preferred Employers Insurance Company – San Diego
- SIU SCIF - Valencia
- SIU SCIF - San Francisco

January 2009

- Concord /Clayton Rotary Club Applicant Fraud Presentation
- CDI/NICB/SIU Roundtable Meeting in Fresno
- Consortium Meeting – Inland Empire
- NICB/SIU Training

February 2009

- Disability Management Employer Coalition – Stanislaus County

March 2009

- CDI/NICB/SIU Roundtable Meeting in Fresno
- SIU Keenan and Associates – Inland Empire

April 2009

- Northern California Fraud Investigators Association Presentation – Monterey
- SIU/DA/CDI Outreach Training
- International Association of Financial Crime Investigators
- SIU Keenan and Associates – Los Angeles

May 2009

- Northern California Workers' Compensation Forum
- SIU Berkshire Hathaway
- SIU Quarterly Meeting – Silicon Valley

June 2009

- SIU Avizent Insurance Company
- Employer Fraud Task Force Meeting – Inland Empire
- SIU Zenith Insurance Corporation
- SIU Wawanesa Insurance Company

Governmental Outreach

The Fraud Division participates in Labor Council meetings, held regularly each month at the Capitol. In attendance are representatives from State agencies, as well as representatives from various labor related affiliates. Those who regularly attend these meetings are legislators, or their staff members, and members of the Board of Equalization or their staff members. Among those who have attended these meetings have been a Governor's Cabinet Secretary, the State Controller, and the Labor Commissioner. During these meetings, the Fraud Division gives updates on workers' compensation anti-fraud activities that have occurred throughout the State.

July 2008

- CDI/NICB/SIU Roundtable Meeting
- Underground Economy Task Force

September 2008

- San Bernardino County Workers' Compensation Unit

October 2008

- Underground Economy Task Force
- Copswest – Law Enforcement Exposition
- Underground Economy Conference

November 2008

- Underground Economy Task Force

December 2008

- Monterey District Attorneys Office

February 2009

- Contra Costa/Marin County Workers' Compensation Fraud Training Seminar

March 2009

- Los Angles County CAO

April 2009

- California Department of Corrections – Mule Creek State Prison
- Underground Economy Conference – Sacramento
- Orange County District Attorneys Office

June 2009

- Kern County SIU Meeting
- CSLB Underground Economy Summit

State Operations – Workers' Compensation Fraud Program

Workers' Compensation SFC Reporting/Trends

Suspected Fraudulent Claims (SFC) are reports of suspected fraudulent activities received by CDI from various sources, including insurance carriers, informants, witnesses, law enforcement agencies, fraud investigators, and the public. The number of suspected fraudulent claims represents only a small portion having been reported by the insurers and does not necessarily reflect the whole picture of fraud as many fraudulent activities have not been identified or investigated.

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

- Extensive efforts to provide training to insurance claim examiners and SIU personnel by the Fraud Division. (See Advisory Task Force recommendations, Pages 167-168)
- The ability of the FD-1 Form to be electronically submitted through the internet.
- The Department has promulgated new SIU regulations to 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 attorney aggressive outreach programs.

For fiscal year 2008-09, the total number of SFCs is reported at 5,174.

Fiscal Year	Number of Suspected Fraudulent Claims
2008-09	5,174
2007-08	4,973
2006-07	5,933
2005-06	8,509
2004-05	6,492
2003-04	5,122

Budget

Workers' Compensation Fraud Program Budget - Fiscal Year 2008-09

Personnel Years (PY) 111.6

Personal Services $11,316,828

Operating Expenses & Equipment (OE&E)..... $4,629,950

CDI Administrative Support..... $4,321,088

Total $20,267,866

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. In Fiscal Year 2008-09, examples include four separate investigations resulting in arrests and convictions where fraudulent brokers embezzled more than $24 million dollars from carriers, including workers' compensation insurance carriers. The costs for the investigation of this case and similar cases is derived from fees and licensing funds within the Department.

In addition to the investigation of cases involving brokers and agents, computer forensics team (CFT) members from the Investigation Division routinely assist the Fraud Division during search warrants. Some of the most knowledgeable and experienced CFT members within the Enforcement Branch are Investigation Division investigators. 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.

Fiscal Year 2008-09 through Fiscal Year 2010-11 Budget

	2008-09 Actual	2009-10 Projected	2010-11 Proposed
Personnel Years	111.6	114.0	114.0
Personal Services	$11,316,828	$11,209,173	$11,545,448
OE&E	$4,629,950	$4,321,633	$4,408,066
CDI Administrative Support	$4,321,088	$4,021,364	$4,101,791
Total:	$20,267,866	$19,552,170	$20,055,305
FAC Approved Level:	$20,284,268	$21,298,200	N/A

Program Support

Fraud Division

The Department of Insurance spent 21.3 percent of the actual expenditures for administrative support activities, which included the following areas:

- **Insurance Commissioner's Office** – The Insurance Commissioner, as an elected official, is responsible for the oversight of the insurance industry, the protection of consumers, and to make certain the insurance marketplace is cultivated to be vibrant and stable. The Insurance Commissioner is often called upon to answer requests for regulatory and enforcement actions from the Governor's Office, the Legislature, the citizenry of the State, and numerous constituents regarding workers' compensation fraud related matters.
- **Statewide Pro Rata (e.g., Governor's Office, Legislature, etc.)** – The Pro Rata process apportions the costs of providing central administrative services to all state departments and funding sources that benefit from the services. Amounts apportioned to special funds for their fair share of central administrative services costs are transferred from the special funds to the General Fund. The amount assessed the Fraud Division for the Workers' Compensation Insurance Fraud Program for Fiscal Year 2008-09 was $1,047,376.
- **Legal Branch** – The attorneys from the Legal Branch represent the Fraud Division on a variety of matters and issues. In addition to supporting the Fraud Assessment Commission, attorneys from the Legal Branch have promulgated emergency regulations, provided legal analysis, and monitors qui tam actions. Currently, the Legal Branch is monitoring approximately **53** qui tam actions, four of which involve workers' compensation issues. The Legal Branch has noticed the increased use of qui tam actions as a remedy by insurance companies to re-coup claims money, especially from surgery centers and durable medical goods suppliers.

Examples of our Legal Branch's intercession in qui tam civil suits were settlements with surgery centers, durable medical goods supply, and medical providers that will save California employers millions of dollars.

In addition, attorneys from the Legal Branch oversee statutory online reporting of workers' compensation convictions, provide counsel to the auto and organized auto

fraud programs, review and modify criminal subpoenas and search warrants as well as handle internal investigations and disciplinary actions against CDI peace officers.

- **Budget and Revenue Management Bureau (BRMB)** – The Budget and Revenue Management Bureau prepares the Fraud Division's annual budget and other financial documents, as well as provides technical assistance to program managers in carrying out the Division's spending plan, including developing the baseline budget and budget change proposals. The Bureau also works with the State's control agencies to ensure spending authority for the Fraud Division and Local Assistance.

During the 2008-09 Fiscal Year, BRMB personnel, as well as Fraud Division management, met with representatives with the Department of Finance (DOF), the Legislative Analyst's Office (LAO), and the Senate Finance sub-committee relative to the Budget Change Proposal (BCP) that increased Local Assistance funding for Fiscal Years 2008-09 and 2009-10.

- **Human Resources Management Division (HRMD) –** Human Resources Management Division assists the Fraud Division's management and staff with the hiring, promoting, and transferring of employees. HRMD is also responsible for the Fraud Division's training, health and safety programs, timekeeping, and various employee payroll and benefit issues.
- **Accounting Services Bureau (ASB)** – In addition to paying the Department's bills, the Accounting Services Bureau tracks restitution received because of judgments made following workers' compensation fraud convictions. This includes the receipt and tracking of fines for criminal 3700.5 Labor Code violations. The ASB also tracks the receipt from the collections of Department of Industrial Relations (DIR) assessments, based on the Fraud Assessment Commission's aggregate determination. In addition, the ASB is responsible for distributing grant award funds to the district attorneys. The ASB also is responsible for the Payroll Unit, which ensures Fraud Division personnel receive timely and correct payments and benefits.
- **Media Relations** – Media Relations is responsible for issuing press releases and coordinating press conferences for fraud related matters. Media Relations also assists in outreach efforts by promoting arrests, convictions, and the consequences of perpetrating fraud. Media Relations also is responsible for the upkeep of the Department's website.

Staffing

- In Fiscal Year 2008-09, the Fraud Division expended 111.6 workers' compensation personnel years.

Distribution of Workers' Compensation Program Hours

As previously stated in this report, the Fraud Division's mission is to actively investigate and arrest those who commit insurance fraud. 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. For Fiscal Year 2008-09, investigative

staff spent 84.5 percent of program hours on case and direct/program support; the remaining 2 percent was indirect time and 13.5 percent time off.

The Division spent 45.3 percent of its time directly on the Workers' Compensation Program, while the remaining 54.7 percent was distributed throughout the other four 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 analysis
- Budget monitoring and proposals
- Property/evidence control
- Fraud Assessment Commission support

Division Headquarters – Compliance Support Activities

Fraud Division Headquarters supports all regional office operations, including those activities related to the management of the statewide grant programs, as well as centralized support of investigations.

- The Special Investigative Unit (SIU) Compliance Review Office conducts audits of insurance companies for compliance with applicable provisions of the Insurance Code and California Code of Regulations. Insurers and employers are required by law to report suspected fraudulent claims to the local district attorney and CDI Fraud Division.

SIU Compliance Review Office – 2008-09 Fiscal Year

The SIU Compliance Review Office audit staff conducted 11 audits of primary insurance companies, which included 36 subsidiaries, for a total of 47 companies. Audits are conducted of the primary insurance company and all related subsidiaries, which are serviced by the primary insurer's SIU. Insurers selected for audit were based upon risk criteria, which included no prior audit; quantity and quality of suspicious insurance fraud referrals to CDI; and incomplete or inaccurate annual SIU compliance reports.

Of the 47 total insurance companies reviewed, 11 were authorized to write and are currently writing workers' compensation insurance in California. Six of the primary companies reviewed were located outside of California, while one company encompassed on-site examinations at various locations in and outside of the state.

Audit Reports

Once an SIU compliance review is completed, a preliminary report (or Exit Review Report) is issued to the company identifying proposed findings and recommendations. The insurer is given 30 days to respond and provide supporting documents and information, after which a Final Report of Findings (final report) is issued to the Insurer. The final report may show that all findings have been resolved and the company complies with the SIU regulations, or that all or some of the findings still stand and are subject to CDI's administrative hearing process and possible fines/penalties. If a company is audited and in full compliance, there are no findings and no preliminary report is necessary; the company will be issued a final report indicating that there are no findings.

Common Findings of Workers' Compensation Companies:

- Not all case incidents of suspected fraud were reported to district attorneys, CDI
- Companies did not identify and investigate all incidents of possible suspected premium fraud
- Fraud referrals (FD-1s) contain errors/omissions
- Fraud referrals submitted on outdated forms (FD-1s)
- Not all incidents of possible suspected insurance fraud are being referred to the SIU for investigation
- Written anti-fraud procedures inadequate
- SIU investigation procedures inadequate
- Continuing training not received by all SIU staff members
- New-hire anti-fraud orientation not provided to all new employees within 90 days
- Annual anti-fraud training not provided to all integral anti-fraud personnel
- Training records incomplete
- Annual compliance report inaccurate or incomplete

Fraud Grant Audit Unit – 2008-09 Fiscal Year

During Fiscal Year 2008-09, the Fraud Grant Audit Unit completed fiscal audits of 14 county district attorneys' offices that participate in the Workers' Compensation Insurance Fraud Program. Counties were selected for audit based on risk criteria, which include but are not limited to prior audit findings, the length of time since the last California Department of Insurance audit, and the grant award amount. The purpose of the audit is to help ensure that the county district attorney's office administers the grant in compliance with the applicable statutes and regulations, the grant award agreement, and the request for application guidelines.

Audit Reports

Once the Fraud Grant Audit Unit completes its analysis, a preliminary report is issued to the county district attorney's office and copied to the CDI Enforcement Branch Deputy

Commissioner and Enforcement Branch Headquarters Chief. The preliminary report identifies the proposed audit findings, observations, and recommendations. The district attorney's office is given 30 calendar days to respond and provide supporting documentation. After careful consideration of the response to the preliminary report, the Final Audit Report is issued to the district attorney's office and copied to the CDI Enforcement Branch Deputy Commissioner, Workers' Compensation Bureau Chief, Regional Office Captain, Enforcement Branch Headquarters Chief, Program Manager, and Legal Counsel. The Final Audit Report incorporates the district attorney's office's response to the preliminary report, including any corrective actions that have been taken to resolve the findings or observations. The audit findings, particularly repeat findings and/or unresolved findings, may affect a county district attorney's office's future grant funding.

Common Findings

- Expenditure report not submitted or not submitted timely
- Independent financial audit report not submitted timely
- Inadequate documentation of salaries and benefits
- Inaccurate closed case log

Background

The Fraud Division, established by statute in 1979, provides all investigative and supporting services necessary to implement and manage statewide Workers' Compensation, Automobile, Property & Casualty, and Health/Disability Insurance Fraud Grant Programs. In Fiscal Year 2008-09, the Fraud Division's total budget and staffing for maintaining the above programs was $44,568,258 and 302 authorized positions, of which 287 personnel years (PY) were expended.

In Fiscal Year 2008-09:

- The Fraud Division maintains ten regional offices statewide serving all 58 counties, of which 37 grants were awarded to 39 counties participating in the Workers' Compensation Insurance Fraud Grant Program. Thirty-five grants for 37 counties were awarded in the Automobile Insurance Fraud Grant program; ten counties participated in the Organized Auto Fraud Activity Interdiction Task Force (AB 1050) and five counties in the Health/Disability Insurance Fraud Grant Program.

Public Access

The CDI, via its public Web site, also provides Internet access to informational outreach materials regarding the activities of the Fraud Division that includes:

- Insurance Fraud Reporting Forms
- Where to Report
- Division Headquarters Profile
- Fraud Assessment Commission web page
- Press Releases

- Regulations - Workers' Compensation Insurance Fraud Program, Automobile Insurance Fraud Program, Organized Automobile Fraud Activity Interdiction Program, Disability and Healthcare Insurance Fraud Program, Special Investigative Units (SIU)
- Workers' Compensation Insurance Fraud
- Automobile Insurance Fraud
- Property, Life and Casualty Insurance Fraud
- Disability and Healthcare Insurance Fraud
- Insurer Special Investigative Units
- Fraud Newsletters
- District Attorney Program Report
- Workers' Compensation Convictions

Industry Relationships

The Fraud Division maintains ongoing liaison with the insurance industry by interacting with the following groups:

- International Association of Special Investigation Units
- Insurance Fraud Advisory Board
- National Insurance Crime Bureau Regional Advisory Committee
- California Coalition on Workers' Compensation
- California Workers' Compensation Institute
- Northern California Fraud Investigators Association
- Southern California Fraud Investigators Association

Governmental Relationships

The Division maintains routine and specific liaison with the following State agencies or entities on matters of overlapping jurisdiction or mutual concern:

- California Peace Officer's Association
- California Peace Officer Standards and Training - Instructor Standards Counsel
- California Highway Patrol
- Employment Development Department
- Department of Industrial Relations; Division of Workers' Compensation, Division of Labor Standards Enforcement
- Department of Consumer Affairs; Bureau of Automotive Repair, California Contractors State License Board, Cemetery and Funeral Bureau
- State Compensation Insurance Fund

- Department of Justice
- Department of Corporations
- Franchise Tax Board
- California Board of Chiropractic Examiners
- California District Attorneys Association
- National Association of Insurance Commissioners
- The Statewide Vehicle Task Force
- Advisory Committee on Automobile Insurance Fraud
- Department of Corrections and Rehabilitation
- Alcoholic Beverage Control

Intergovernmental Task Forces

The Fraud Division participated in the following intergovernmental anti-fraud task forces. Many cases from these investigations are spread across more than one fraud program:

- Underground Economy
    - California Joint Underground Economy Task Force
    - Orange County Investigation and Premium Fraud Underground Economy Team
    - Employment Enforcement Task Force
    - Bay Area Premium Fraud Coalition
    - Riverside County Uninsured Employer Task Force
    - Premium Fraud Task Force
    - Ventura County Underground Economy/Employers' Fraud Task Force
    - Underground Economy Task Force (Santa Clara)
    - Underground Economy Task Force (Sacramento)
    - Premium Fraud Task Force (Central Valley)
- Los Angeles County Workers' Compensation Interdiction Program
- CDI and Department of Industrial Relations Committee on Professional Employer Organizations
- Health Care Task Force
- Department of Health Services Fraud and Abuse Steering Committee
- High Tech Crimes Task Force
- California Department of Justice RX-NET
- CDI Disaster Fraud Task Force
- CDI Urban Grant Task Forces (8)
- Cargo Theft Interdiction Program
- Orange County Auto Theft Task Force

- Los Angeles County Task Force for Regional Auto Theft Prevention
- Riverside Auto Theft Task Force
- San Diego Auto Theft Task Force
- Sierra/Sacramento Arson Task Force
- California Anti-Terrorism Information Center

Supplemental Data and Information

1.) District Attorney Funding for Fiscal Year 2008-09
2.) Enforcement Branch Offices and Assigned Counties
3.) Major Operations for Fiscal Year 2008-09
4.) Suspected Fraudulent Claims (Calendar Years 2007 through 2009)
5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09)
6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09)
7a.) Arrest-Prosecution Summary (Part One)
7b.) Arrest-Prosecution Summary (Part 2)
7c.) District Attorney's Type of Investigations – Fiscal Year 2008-09
8a.) Standard and Medium Cases in Court
8b.) Complex and Very Complex Cases in Court
8c.) Cases in Court - Prosecuting Caseload
9a.) Case Referrals—Part One
9b.) Case Referrals—Part Two
10.) Press Clippings for Fiscal Year 2008-09

1.) District Attorney Funding for Fiscal Year 2008-09

County	Funding Requested	FY 2008-09 Funding Awarded	FY 2008-09 First Distribution	FY 2008-09 Final Distribution
Alameda	$1,273,874	$1,273,874	$573,243	$700,631
Amador	$536,011	$536,011	$241,205	$294,806
Butte	$218,741	$191,980	$86,391	$105,589
Contra Costa	$724,052	$551,000	$247,950	$303,050
El Dorado	$295,000	$237,800	$107,010	$130,790
Fresno	$1,281,610	$1,096,200	$493,290	$602,910
Humboldt	$262,499	$80,018	$36,008	$44,010
Imperial	$72,773	$57,425	$25,841	$31,584
Kern	$1,170,052	$1,000,000	$450,000	$550,000
Kings	$279,108	$279,108	$125,599	$153,509
Los Angeles	$5,282,006	$5,282,006	$2,376,903	$2,905,103
Madera	$77,602	$48,000	$21,600	$26,400
Marin	$200,013	$170,000	$76,500	$93,500
Mendocino	$37,209	$36,000	$16,200	$19,800
Merced	$160,506	$144,000	$64,800	$79,200
Monterey	$561,295	$450,000	$202,500	$247,500
Orange	$3,281,140	$2,250,000	$1,012,500	$1,237,500
Riverside	$1,125,042	$1,000,000	$450,000	$550,000
Sacramento	$991,569	$900,000	$405,000	$495,000
San Bernardino	$2,111,640	$2,111,640	$950,238	$1,161,402
San Diego	$5,305,550	$4,900,000	$2,205,000	$2,695,000
San Francisco	$1,029,712	$900,000	$405,000	$495,000
San Joaquin	$679,217	$637,222	$286,750	$350,472
San Luis Obispo	$110,000	$94,000	$42,300	$51,700
San Mateo	$691,989	$575,000	$258,750	$316,250
Santa Barbara	$248,398	$248,398	$111,779	$136,619
Santa Clara	$2,656,178	$2,100,000	$945,000	$1,155,000
Santa Cruz	$218,733	$85,680	$38,556	$47,124
Shasta	$154,351	$154,351	$0	$154,351
Siskiyou	$23,556	$23,556	$10,600	$12,956
Solano	$166,581	$166,581	$74,961	$91,620
Sonoma	$217,255	$217,255	$0	$217,255
Tehama	$33,865	$25,000	$11,250	$13,750
Tulare	$298,624	$279,939	$125,973	$153,966
Tuolumne	$41,630	$23,200	$0	$23,200
Ventura	$717,203	$717,203	$322,741	$394,462

1.) District Attorney Funding for Fiscal Year 2008-09 (continued)

County	Funding Requested	FY 2008-09 Funding Awarded	FY 2008-09 First Distribution	FY 2008-09 Final Distribution
Yolo	$152,877	$152,877	$68,795	$84,082
TOTAL	**$32,687,461**	**$28,995,324**	**$12,870,233**	**$16,125,091**

2.) Enforcement Branch Offices and Assigned Counties

Fraud Division

Name	Address	Counties Served
Benicia	1100 Rose Drive Benicia, CA 94510 (707) 751-2000	Alameda, Contra Costa, Del Norte, Humbolt, Lake, Marin, Mendocino, Napa, San Francisco, Solano, & Sonoma
Fresno	1780 East Bullard, Suite 101 Fresno, CA 93710 (559) 440-5900	Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, San Luis Obispo & Tulare
Inland Empire	9674 Archibald Ave., Suite 100 Rancho Cucamonga, CA 91730 Phone: (909) 919-2200	Riverside & San Bernardino
Los Angeles	5999 East. Slauson Ave. City of Commerce, CA 90040 Phone: (323) 278-5000	Los Angeles
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 & Yuba
San Diego	1495 Pacific Highway, Suite 400 San Diego, CA 92101 Phone: (619) 699-7100	Imperial and San Diego
Silicon Valley	18425 Technology Drive Morgan Hill, CA 95037 Phone: (408) 201-8800	Monterey, San Benito, San Mateo, Santa Clara & 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 & Ventura

2.) Enforcement Branch Offices and Assigned Counties (continued)

Investigation Division

Name	Address	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, & Solano
Inland Empire	9674 Archibald Ave., Suite 100 Rancho Cucamonga, CA 91730 Phone: (909) 919-2200	Inyo, Riverside & San Bernardino
Los Angeles	300 South Spring St., 10th Floor Los Angeles, CA 90013 Phone: (213) 346-6006	Central & 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, & Yuba
San Diego	1350 Front Street, Room 4061 San Diego, CA 92101 Phone: (619) 652-5600	San Diego
Valencia	27200 Tourney Road, Suite 330 Valencia, CA 91355 Phone: (661) 253-7500	Fresno, Kern, Kings, Madera, Mariposa, Merced, Northern Los Angeles, San Luis Obispo, Santa Barbara, Tulare, & Ventura

3.) Major Operations for Fiscal Year 2008-09

Premium Fraud

Staffing Services, Inc. (05CW021578) – David Zahler of Huntington Beach and David Tai of Hacienda Heights surrendered to police on November 26, 2008 and were charged with conspiring to defraud the State Compensation Insurance Fund (SCIF) of more than $20 million dollars in insurance premiums.

Zahler and Tai allegedly conspired to withhold insurance premiums they owed for the workers' compensation policy issued to Staffing Services, Inc., a temporary employment company with thousands of employees. It is alleged that the men purposely misrepresented the types of employees for which they obtained workers' compensation coverage, in order to pay $18 million less in premium payments. Zahler was the Chief Executive Officer and Tai the Chief Financial Officer for Staffing Services. Staffing Services Headquarters is located in the City of Bellflower.

CDI launched an investigation into Staffing Services after SCIF notified the California Department of Insurance of this suspected fraud. The investigation revealed that David Zahler and David Tai were allegedly providing false information to SCIF to obtain workers' compensation insurance coverage for less than should have been due for their insurance coverage.

Prosecuting Authority: Los Angeles County
Fraud Type: Premium Fraud/Misclassification
Status: Pending

Bell Building Maintenance (06JW004824) – On April 16, 2009, Andrew Kim (aka Sung Young Kim), 43, and Chan Hee Yang (aka Chan Hee Ko), 61, both of Northridge, were arrested by the California Department of Insurance on multiple counts of insurance premium fraud and conspiracy connected to Bell Building Maintenance Company, a janitorial business based in Sherman Oaks. The alleged fraud amounts to more than $6.3 million dollars.

Bell Building Maintenance Company, through Chan and Kim, allegedly misrepresented the number of employees working for the janitorial company in an effort to reduce the proper rate of workers' compensation insurance premium. The criminal investigation was launched in September of 2006 based upon a referral from SCIF.

According to payroll reports allegedly submitted to SCIF by Kim, from 2000 to 2005, the only employees of the company consisted of Kim and his wife. As a result, the company was only required to pay the minimum amount of premium to receive a workers' compensation insurance policy during this period. However, the investigation revealed that, in reality, Bell Building Maintenance Company was a much larger operation that employed hundreds of janitors servicing numerous private companies and public entities in Los Angeles, Ventura, Orange, San Bernardino and Riverside counties. Chan, who is not Kim's wife, was later identified as the company's corporate president during this period.

Kim has been formally charged with one count of criminal conspiracy; ten counts of presentation of false/fraudulent writing to a public entity; one count of misrepresentation to obtain a lower rate with SCIF; and one count of misrepresentation to obtain a lower

rate with a carrier other than SCIF. All charges are all felonies. His bail has been set at $3.28 million dollars.

Chan has been formally charged with one count of criminal conspiracy; ten counts of presentation of false/fraudulent writing to a public entity; one count of misrepresentation to obtain a lower rate with SCIF; one count of misrepresentation to obtain a lower rate with a carrier other than SCIF; one count of failure to pay tax; one count of filing a false tax return; one count of failure to make contributions; and one count of failure to make contributions to the Disability Fund. All charges are all felonies. Her bail has been set at $3.3 million.

Prosecuting Authority: Los Angeles County
Fraud Type: Premium Fraud/Underreporting Wages
Status: Pending

Nurse Connection, Inc. (08CW016438) – Joseph Baiden, 56, of Diamond Bar, surrendered yesterday morning to the Los Angeles Superior Court pursuant to an arrest warrant issued for eight counts of workers' compensation insurance premium fraud against SCIF. Baiden is being held on $1.64 million bail.

In September 2008, CDI received a referral from SCIF alleging that Baiden, doing business as Nurse Connection, Inc., was underreporting his workers' compensation payroll on the quarterly payroll reports. According to the referral, SCIF received an anonymous tip that Baiden had falsified payroll records as well as California and federal tax filings for the years 2001-07. It is alleged that Baiden misrepresented $20 million in Nurse Connection's payroll to conceal the actual risk to the insurance carrier, thereby illegally reducing his workers' compensation insurance premiums. SCIF's estimated loss over this seven-year period is approximately $1.4 million.

Along with the arrest, CDI froze Baiden's bank accounts and seized numerous properties throughout the Los Angeles area estimated at $4 million. His primary residence was located in an exclusive, gated hilltop neighborhood in Diamond Bar.

The arrest came as the result of an investigation by the California Department of Insurance (CDI). The case is being prosecuted by the Los Angeles County District Attorney's Office. Each count is a felony and, if convicted on all counts, Baiden faces a maximum of 40 years in prison as well as $3.2 million in fines. Based on the investigation, additional charges may be filed at a later date.

Prosecuting Authority: Los Angeles County
Fraud Type: Premium Fraud/Underreporting Wages
Status: Pending

Armando Rios (05FW000239) – Armando Rios of Reedley was arrested on Mary 29, 2007 on four counts of workers’ compensation insurance premium fraud and nine felony counts of failure to remit withheld payroll taxes.

Armando Rios, DBA Rios and Sons Farm Labor Services, under reported payroll to the State Compensation Insurance Fund (SCIF). Records provided to the Employment Development Department (DE-6) reflected amounts that were in excess of those reported on SCIF monthly payroll reporting. The payroll reports submitted by the policyholder during the period from January 1, 2003 to January 1, 2004 totaled

$2,582,000, but the year-end audited dollars totaled $5,289,000. This is an additional $2,700,000 in payroll not reported to SCIF on the required monthly payroll reports. Currently, this employer has an outstanding balance owing of $307,970. The outstanding balance represents misrepresentation of payroll by classification and underreporting to SCIF.

Prosecuting Authority: Fresno County
Fraud Type: Premium Fraud/Underreporting Wages
Conviction: On March 12, 2009, Armando Rios pled guilty to one count of insurance premium fraud. Rios is scheduled to receive his sentencing in March 2010.

Charles Hall (07BW008004) – Charles Hall, a workers' compensation insurance agent, was convicted on October 6, 2008 on three counts of making a false or fraudulent statement for the purpose of reducing the premium, rate, or cost of the insurance.

Charles Hall was providing rate quotes based upon his adding false applicant addresses, in less expensive premium rate locales, to insurance applications. When the victim clients failed to receive premium bills, it was discovered that the bills were being sent to false addresses; this continued for approximately two years. Ultimately, Hall's victim employer, McDonald-Leavitt Insurance Agency, lost approximately $130,000 in unpaid premiums.

Prosecuting Authority: Sonoma County
Fraud Type: Premium Fraud
Conviction: On October 6, 2008, Charles Hall was sentenced to 122 days in county jail, 40 hours of community service, and three years probation. In addition, Hall was ordered to pay $56,364 in restitution, $600 in criminal fines, and $440 in civil fines.

Paul Hamilton Construction (05HW013557) – Paul Hamilton and his wife Susanna Hamilton were arrested on June 12, 2008 and each charged with one count of workers' compensation insurance premium fraud.

Paul and Susanna Hamilton formerly owned the Hamilton's contracting and construction company, Paul Hamilton Construction/Cal Tech Restoration & Construction in Temecula. The suspects misreported the true number of their employees and vastly underreported the company's payroll to SCIF, which allowed them to pay far less than the proper rate for their workers' compensation insurance. The premium loss is currently estimated to be at $493,836.

Prosecuting Authority: Riverside County
Fraud Type: Premium Fraud/Underreporting Wages
Conviction: On May 14, 2009, Paul Hamilton was sentenced to 60 days in county jail and three years probation. Susanna Hamilton was sentenced to 80 hours of community service and three years probation. Together, they were also ordered to pay $493,836 in restitution and $808 in criminal fines.

Gerald Quint and Susan Stommel (05GW019185) – Gerald Quint and Susan Stommel were both arrested on February 14, 2007 on 14 felony charges including workers' compensation insurance fraud, grand theft, income and corporate tax evasion and unemployment insurance tax evasion.

Quint and Strommel owned and operated New Century Transportation, Inc., a Nevada corporation registered in California.

The investigation revealed that between 2004 and 2006, New Century failed to report over $4.5 million in paid wages to the Employment Development Department (EDD) as required by law. The defendants deducted personal income taxes and disability taxes from employees' wages during that time, but pocketed the funds instead of remitting them to EDD. The alleged illegal actions caused an estimated total loss of nearly $3 million to the State of California and the workers' compensation carriers.

The arrests were a result of a joint investigation by the Santa Clara County District Attorney's Office, as the lead agency, with assistance from the Fraud Division, the Franchise Tax Board, and the Employment Development Department.

Prosecuting Authority:	Santa Clara County
Fraud Type:	Premium Fraud/Underreporting Wages
Conviction:	On April 1, 2009, Susan Stommel pled guilty and later received a sentence of one year in county jail and five years probation. Stommel was also ordered to pay $2,898,201 in restitution. Gerald Quint pled guilty on July 30, 2009 and his sentence is pending.

Collaborative Efforts with Allied Agencies

San Joaquin Valley Premium Fraud Task Force[1]

Firm Build, Inc. (07FW019089) – Rudy Buendia II, Rudy Buendia III, Christina Ledezma, and Joseph Cuellar we arrested on September 12, 2008 and charged with workers' compensation premium fraud, embezzlement, grand theft, and diversion of construction funds.

All were employed at Firm Build, a non-profit organization that had been created by the Housing Authority of Merced County for the initial purpose of providing construction job skills training for Housing Authority tenants.

An audit by SCIF identified unreported wages from 2003 to 2006. SCIF also identified $85,000 in unreported wages in one quarter in 2007. In addition to the insurance premium fraud, the Merced County District Attorney's Office is also investigation allegations of embezzlement by Firm Build Management.

Prosecuting Authority:	Merced County
Fraud Type:	Premium Fraud/Underreporting Wages
Status:	Pending

[1] *The San Joaquin Premium Fraud Task Force is comprised of prosecutors, investigators, and support personnel from the Fraud Division and district attorney's offices in Merced, Fresno, Tulare, Kings, and Kern Counties.*

Gonzales Farm Services (06FW015378) – On January 16, 2009, Dominick Gonzales was convicted on two counts of insurance fraud.

Dominick Gonzales, owner of Gonzales Farm Services, obtained a re-instatement of his farm labor contractors' license after his father, Larry Gonzales, had his workers' compensation insurance coverage cancelled by SCIF.

Upon reviewing Dominick Gonzales' monthly payroll reports to SCIF, it was noted that he reported minimal payroll compared to the business report he submitted to the Employment Development Department for the same period. A search warrant was served on Gonzales Farm Services, which located employee payroll records verifying that Dominick Gonzales was underreporting his business payroll and misclassifying the type of work his employees were performing.

Prosecuting Authority:	Kern County
Fraud Type:	Premium Fraud/Underreporting Wages/Misclassification
Conviction:	On January 16, 2009, Dominick Gonzales was sentenced to 50 hours of community service and three years probation. In addition, Gonzales was ordered to pay $19,155 in restitution and $365 in criminal fines.

Fernandez Nursery and Packing (05FW017102) – On January 30, 2009, Adrian Jimenez pled no contest and was convicted on one count of denying access to insurance benefits and one count of theft.

Adrian Jimenez worked as the bookkeeper in a large-scale nursery operation. Jimenez canceled the workers' compensation insurance for the nursery, set up his own false workers' compensation company, which paid into his own checking account.

State Compensation Insurance Fund (SCIF) reported Fernandez Nursery and Packing obtained a workers' compensation insurance policy 2003. During a payroll audit, auditors discovered that Fernandez Nursery and Packing had underreported over $195,000 in payroll through EDD records. The underreported payroll resulted in a workers' compensation premium loss to SCIF of over $25,000. Because of failing to pay the premium payment Fernandez Nursery and Packing's workers' compensation insurance policy was cancelled on December 23, 2004.

On May 9, 2006, a search warrant was served on the Fernandez Nursery and Packing business office and the residence of Adrian Jimenez to search for payroll records and evidence of workers' compensation insurance coverage. Jimenez was interviewed during the search warrant and admitted he underreported employee payroll to SCIF with an explanation he thought he did not have to report family member payroll.

It was discovered that Adrian Jimenez did not obtain workers' compensation insurance coverage for Fernandez Nursery and Packing after the SCIF policy was cancelled. Instead, Jimenez began collecting the Fernandez Nursery and Packing workers' compensation insurance premium payments under a fictitious insurance company name called "Compensation Insurance Group." The owners of Fernandez Nursery and Packing were not aware Jimenez was collecting the premium payments under an

assumed business name and provided a cancelled business check showing Compensation Insurance Group (Jimenez) had been paid over $48,000 in one month.

Prosecuting Authority:	Merced County
Fraud Type:	Premium Fraud/Underreporting Wages/Embezzlement
Conviction:	On March 26, 2008, Adrian Jimenez was sentenced to 180 days in county jail and three years probation. In addition, Jimenez was ordered to pay $240,698 in restitution and $532 in civil fines.

Petronella Roofing Company (06DW021975) – This is the largest known Workers' Compensation Insurance fraud case in California's history. Michael Vincent Petronella, 50, and his wife Devon Lynn Kile, 44, both of Laguna Hills, are charged with 106 felony counts including conspiracy to commit a crime, grand theft, insurance fraud, filing a false tax return, willfully failing to file or filing fraudulent tax returns, misrepresenting facts to SCIF, making fraudulent statements, making false statements to discourage an injured worker from claiming benefits, misrepresenting facts to workers' compensation insurance company, and failing to file a return with the intent to evade tax. The defendants both face sentencing enhancements and allegations for aggravated white-collar crime over $2.5 million, $500,000, and $100,000. If convicted on all counts, the defendants each face a sentence ranging from five years and four months up to 102 years in state prison. Bail was set at $10 million and each had to prove the money was from a legal and legitimate source before posting bond.

Petronella is a roofing and general building contractor. Petronella and Kile own three businesses including Petronella Corporation, Western Cleanoff, Inc., and The Reroofing Specialists, Inc. (also known as Petronella Roofing). The businesses are located in Costa Mesa and Cathedral City, Riverside County, and have clients primarily in Southern California, which include the Ocean Institute in Dana Point, Pacific Amphitheater in Costa Mesa, and other commercial properties.

In March 2006, an employee of Petronella fell from a roof and sustained injuries. A payroll stub was submitted to SCIF listing his employer as Western Cleanoff, Inc., which SCIF did not insure. SCIF reported the suspected fraudulent claim to the Orange County District Attorney's Office (OCDA) and the Department of Insurance.

Following a 2-year investigation by the OCDA with assistance from several agencies (listed below), Petronella and Kile were arrested on April 29, 2009, at their Laguna Hills home. A search of six locations including two residences, two businesses, a storage unit, and a Certified Public Accountant's office turned up more than $500,000 in jewelry, $51,000 cash, and an application from Kile to be featured on the Bravo series Real Housewives of Orange County.

The investigation, which began in 2006, revealed the following: Beginning in 2000, Petronella and Kile are accused of obtaining workers' compensation insurance for their three companies through SCIF. Between 2000 and 2008, Petronella is accused of fraudulently submitting 42 claims for uninsured injured workers and underreporting $29 million in payroll to SCIF in order to avoid paying his workers' compensation insurance premiums. They are accused of engaging in a scheme that resulted in SCIF incurring more than $253,000 in uncovered injured worker claims and insurance premium losses exceeding $38 million. Petronella and Kile are accused of reporting $2.9 million in

payroll to SCIF, while having an actual payroll of $29 million, ten times more than reported. The $38 million premium due includes the $29 million in loss history plus penalties and assessments for inaccurate reporting.

In order to avoid paying workers' compensation insurance for all of his employees, Petronella and Kile are accused of underreporting the number of workers employed at each business, including claiming none for Western Cleanoff, Inc. Petronella is accused of fraudulently filing 42 claims for employees injured while working for The Reroofing Specialists, Inc. to obtain insurance coverage for the injured employee without paying for the insurance. The injured employees have since been identified as Western Cleanoff, Inc. and Petronella, Inc. employees.

This case was investigated by the OCDA and the Orange County Premium Fraud Task Force, a collaboration of investigators from the OCDA, CDI, California Employment Development Department (EDD), Franchise Tax Board, and Contractors State License Board.

Prosecuting Authority: Orange County
Fraud Type: Premium Fraud/Underreporting Wages
Status: Pending

Medical Provider

Shawn Dodd (03FW018451) – Shawn Rene Dodd, of Bakersfield, was arrested on May 13, 2009, and charged with uncertified practice of medicine, making false or fraudulent insurance claims, money laundering, commission of a felony while on bail and selling stocks without a license. Dodd's bail was set at $1,000,000.

Since her previous arrest in 2007, Dodd allegedly continued to operate medical corporations, which were used to fraudulently bill insurance carriers. At one point, insurers were billed for medical services reportedly rendered when there were no doctors present. It is alleged that Dodd attempted to defraud insurance companies of at least $100,000.

Dodd allegedly operated these fraudulent companies while on $500,000 bail for previous felony charges. In January 2007, Dodd was charged with felony insurance fraud, workers' compensation insurance fraud, tax evasion, and money laundering. She was released from Kern County Jail and remained free on bail until her arrest on May 13.

The California Department of Insurance and the Kern County District Attorney's Office jointly investigated this case.

Prosecuting Authority: Kern County
Fraud Type: Medical Provider
Status: Pending

Accident Help Line (03FW003701) – William Sheaffer, Jason Walker, Lorene Hebert, Mark Lungren, and Ronald Richards were administratively re-arrested in July 2009, following indictments by the Merced County Grand Jury for insurance fraud. The suspects were initially charged with insurance fraud in September 2006, however, these

charges were later dropped in anticipation of the case being taken before the Grand Jury. The arrests were the result of a three-and-a-half year investigation.

Undercover operatives and investigators found that various Accident Help line clinics in Hanford, Fresno and Merced allegedly provided excessive and unnecessary treatment to patients for the purpose of over-billing insurance companies. They also allegedly prescribed excessive Total Temporary Disability time off work to patients covered by workers' compensation insurance.

Accident Help Line came to the attention of CDI investigators through complaints, tips and information received from the Special Investigative Units (SIU) of Geico and Zenith Insurance Companies, SCIF, and other insurance carriers. Since late 2002, investigators have received numerous suspected fraud referrals accounting for millions of dollars in suspected workers' compensation insurance fraud.

Prosecuting Authority: Merced County
Fraud Type: Medical Provider
Status: Pending, following the Grand Jury indictments.

Mark Schillinger (05BW019599) – On June 24, 2009, Mark Schillinger, D.C. pled guilty to one count of insurance fraud, presenting a knowingly false or fraudulent written statement in support of a claim for compensation.

After CDI investigators reviewed billing documents received from Dr. Schillinger, it was revealed Schillinger had billed insurance companies for work hardening treatments and mechanical traction treatments which his patients denied receiving.

Prosecuting Authority: Marin County
Fraud Type: Medical Provider
Conviction: On June 24, 2009, Dr. Mark Schillinger pled guilty to one count of insurance fraud and was sentenced to 50 hours of community service and ordered to pay $8,173 in restitution.

Shane Whiteley (06AW020038) – On July 22, 2008, Dr. Shane Whiteley pleaded no contest to one count of making a false or misleading statement in support of a claim and petty theft. He was sentenced to 90 days in county jail, three years probation, and $1,171 in restitution and $6,668 in criminal fines.

In December 2006, Dr. Whitley had closed his California chiropractic offices and moved to Florida. CDI investigators were informed by Travelers Insurance Special Investigative Unit that Dr. Whiteley was suspected of continuing to bill Travelers Insurance for office visits and examinations of his former patients. These services rendered occurred after Dr. Whiteley had moved out of state. In December 2007, Dr. Shane Whiteley was arrested for submitting a false claim for payment of health care benefits and making false or misleading statements in support of a claim(s).

Prosecuting Authority: Sacramento County
Fraud Type: Medical Provider
Conviction: On July 22, 2008, Dr. Shane Whiteley pleaded no contest to one count of making a false or misleading statement in support of a claim and petty theft. He was sentenced to 90

days in county jail, three years probation, and $1,171 in restitution and $6,668 in criminal fines.

Employer Defrauding Employee

NBC General Contractors, Inc. (05BW017902) – Monica Mui Ung, 49, of Alamo; Joey Ruan, 31, of San Leandro; and Tin Wai Wu, 28, of Millbrae were arrested on May 26, 2009, and charged with 48 counts of workers' compensation insurance fraud, labor code violations and tax fraud. Bail was set at $535,000 for each suspect.

The investigation, led by CDI with assistance from the Employment Development Department, revealed that Ung owned and operated NBC General Contractors Inc., a general building contracting company. From May 2003 to May 2007, NBC was awarded at least 27 public works projects in Alameda, Contra Costa, San Francisco, San Mateo and Marin Counties.

The cost for NBC's workers' compensation insurance was determined by employee wages, total amount of payroll and job classifications of the employees. Ung, Ruan, and Wu allegedly made intentional and material misrepresentations to their workers' compensation insurance carrier to misclassify the type of work their employees were performing, as well as falsely reporting the hourly wage of more than 70 employees, saving them a significant amount in workers' compensation premiums.

Because public works projects are typically awarded to the lowest bidder, the alleged fraud gave NBC a significant advantage over competitors. This alleged false reporting resulted in a total loss of premiums of more than $1.45 million.

Additionally, investigators allege that NBC did not pay overtime or sick leave to employees, as required under labor laws. These losses are estimated at $3.6 million in unpaid wages to 19 employees.

Prosecuting Authority: Alameda County
Fraud Type: Premium Fraud/Employer Defrauding Employee
Status: Pending

Beard's Custom Cabinets (08AW005088) – On April 23, 2009, David Beard and Timothy Beard were arrested and charged with failure to disclose an event affecting insurance benefits, discouraging an injured worker from claiming benefits or pursuing a claim, and conspiracy.

An employee of Beard's Custom Cabinets, Justin Kane, suffered work related injuries on three separate occasions, all of which required medical treatment and Kane to miss time off work. On all injuries, Kane was taken to Hilltop Medical by Tim Beard and told to lie to doctors as to where the injuries had occurred. Owner David Beard confessed that he and Tim Beard had discussed that they would lie to medical personnel and he (Dave Beard) would take care of the treatment bills including any time off from work.

Prosecuting Authority: Shasta County
Fraud Type: Employer Defrauding Employee
Status: Pending

Pulo's Italian Restaurant (07AW021891) – Armondo Barboza, owner of Pulo's Italian Restaurant, was arrested on January 29, 2008, and charged with one count of concealing the occurrence of an event that affects any person's right or entitlement to any insurance benefit or payment and one count of conspiring to receive unlawful benefits.

The CDI Fraud Division received a complaint from a Med-7 Urgent Care Center regarding the owner of Pulo's Italian Restaurant. An employee of the restaurant came in to be treated for injury sustained to his hand on November 28, 2007. The clinic attempted to contact the owner, Armondo Barboza, regarding his workers' compensation insurance but Barboza wanted to pay for the treatment with his credit card. The injured employee was interviewed and he stated that Barboza told him that he would pay him cash if he filed for unemployment insurance. The employee was also told he would receive more money if he collected unemployment insurance instead of filing a workers' compensation claim.

Prosecuting Authority: Sacramento County
Fraud Type: Employer Defrauding Employee
Conviction: On November 19, 2008, Armondo Barboza was convicted of one count of conspiring to receive unlawful benefits and was sentenced to 90 days in county jail and three years probation. In addition, Barboza was ordered to pay $1,299 in restitution and $400 in criminal fines.

Embezzlement

Melody Ann Mosqueda (07AW004702) – On August 7, 2009, Melody Ann Mosqueda, 45, of Valley Springs, her former husband, Anthony Charles Mosqueda, 52, of Stockton and their daughter, Rachel Lee Anthony-Mosqueda, 28, of Elk Grove were arrested as the result of an investigation conducted by the CDI into alleged insurance fraud.

Melody Ann Mosqueda is charged with 13 counts of insurance fraud, money laundering, grand theft, and burglary. Rachel Lee Anthony-Mosqueda was arrested by the Elk Grove Police Department and charged with nine counts of insurance fraud, money laundering and grand theft. Anthony Charles Mosqueda faces 10 counts of insurance fraud, money laundering and grand theft. Bail for each family member was set at $250,000. CDI's investigation was assisted by Zurich and Fireman's' Fund insurance companies.

According to CDI detectives, Melody Ann Mosqueda perpetrated an embezzlement scheme while working for Zurich and Fireman's' Fund insurance companies as an insurance claims adjuster from 2003 to 2007 by allegedly inputting false information into legitimate insurance claims, then issuing payment for fictitious settlements and/or services. It is further alleged that these checks were issued to and cashed by Mosqueda and her family members. The Mosqueda family also apparently created several bogus companies to which Melody Ann would then issue insurance payments and subsequently cash those checks.

Prosecuting Authority: San Joaquin County
Fraud Type: Embezzlement
Status: Pending

Broker/Agent Fraud

W.C Surgery Centers (09HW005855) – Rene Montes, 41, of Riverside; Hector Porrata, 45, of Moreno Valley; George Martinez, 42, of Apple Valley; and Cara Cruz-Thompson, 46, of Victorville were arrested on May 6, 2009 charged in connection with a $1.5 million insurance fraud scam. The felony charges include conspiracy to commit grand theft, embezzlement, and insurance fraud.

It is alleged that between August 2003 and January 2006, Rene Montes, who operated W.C. Surgery Centers and W.C.S.C. & Associates fraudulently solicited funds from AIG Claims Services and Matrix Absence Management Inc. for outstanding medical liens on workers' compensation claims for services rendered by medical providers. Montes issued letters to AIG Insurance Company and Matrix Absence Management Inc., indicating that his two companies had been authorized by the medical providers to negotiate, settle, and collect monies to resolve unpaid liens. It is alleged that Montes did not have authority to resolve the unpaid liens.

Porrata, Cruz-Thompson, and Martinez were employed by AIG as workers' compensation insurance adjusters. As AIG employees, the three people allegedly made payments of nearly $1.2 million to W.C. Surgery Centers and W.C.S.C. & Associates.

On February 2, 2007, AIG received a demand on behalf of Coast Plaza Doctors Hospital for payment of almost $100,000 in outstanding medical liens. AIG discovered that they had paid W.C.S.C. & Associates for resolution of the lien. They also learned that they made 49 additional payments totaling almost $1.1 million to W.C.S.C, believing that the company was authorized to handle unresolved liens for various medical providers. AIG confirmed that all fifty payments to W.C.S.C. were paid by only three adjusters: Martinez, Cruz-Thompson, and Porrata.

The California Department of Insurance and Orange County District Attorney's Office investigators discovered that the adjusters had worked together previously at another workers' compensation claims administrator, Matrix Absence Management, where they allegedly defrauded the company out of more than $310,000.

Prosecuting Authority: Orange County
Fraud Type: Broker/Agent Fraud
Status: Pending

Carlos Chavez – Carlos Chavez, a former insurance broker, was convicted of eight felony counts, including one count of elder abuse, four counts of grand theft, and three counts of computer fraud,

Chavez, doing business as Capable Insurance Services, collected funds from at least five clients between August 2006 and September 2007, to purchase various types of insurance. Two of his clients had their insurance coverage cancelled when Chavez failed to remit premiums. Both were forced to repay their premiums to have their policies reinstated. Three other clients were issued counterfeit certificates of insurance making it appear they had legitimate coverage. One of these victims incurred an uninsured loss of $110,000 when his home suffered fire damage.

This case was investigated by the CDI Investigation Division

Prosecuting Authority: Los Angeles County
Fraud Type: Broker/Agent Fraud
Conviction: On August 12, 2009, Carlos Chavez was sentenced to one year in county jail and five years of probation. Chavez was also ordered to pay $119.427 in restitution and $400 in fines.

Ray Wersching Insurance Agency (06BW011597) – Mary Ann Locke, a former co-owner of Ray Wersching Insurance Agency pled guilty to four felony counts including embezzlement and willful participation in the business of insurance following a felony conviction involving dishonesty.

Mary Anne Locke and Raimund Wersching of Ray Wersching Insurance Agency in Redwood City were indicted on numerous counts of embezzlement and premium fraud as a result of a joint investigation with the Department of Insurance, FBI, IRS, and the U.S. Attorney's Office. The allegation is over $20,000,000 in premium diversion on workers' compensation policies. Both were indicted citing $8 million dollars of fraud.

On December 18, 2007, Wersching plead guilty to one count of 26 USC 7203 (Failure to file tax returns) and was sentenced to two years probation, six months home detention and a criminal penalty of $25.00. He was also ordered not to reactivate or re-apply for any license from the Insurance Commissioner of California for a period of ten years.

Prosecuting Authority: U.S. Attorney, Northern District
Fraud Type: Embezzlement
Status: On December 10, 2008, Mary Anne Locke pled guilty to three felony counts and was sentenced to 39 months in Federal prison and three years probation. Locke was also ordered to pay $8,308,411 in restitution and $300 in criminal fines.

Anthony Medina – Anthony Medina was convicted on November 3, 2008 of 152 felony counts including 33 counts of transacting as an insurance company without a certificate of authority and two counts of insurance fraud. Medina was sentenced to ten years in State Prison.

The CDI Investigation Division began investigating this case when an insurance company filed a report after finding a discrepancy in a financed policy taken out through Prompt Insurance Agency. Between June 2003 and November 2007, Medina is accused of operating Prompt Insurance Agency in Newport Beach. The defendant is accused of collecting more than $2,500,000 from 18 business owners under the pretense of securing workers' compensation and general liability insurance policies for them.

Because of Medina's failure to take out insurance policies for some of the businesses, several business owners, and employees suffered losses that should have been covered by insurance. In some cases, employees who had been injured at work did not receive the workers' compensation benefits they were due because Medina had not obtained the policies for their employers.

This case was a joint investigation involving the CDI Investigation Division, the California Franchise Tax Board, and the Orange County District Attorney's Office.

Prosecuting Authority: Orange County
Fraud Type: Broker/Agent Fraud
Conviction: Anthony Medina was convicted on November 3, 2008 of 152 felony counts including 33 counts of transacting as an insurance company without a certificate of authority and two counts of insurance fraud. Medina was sentenced to ten years in State Prison.

Claimant Fraud

Richard Salas (08CW021765) – On May 13, 2009, Richard Salas was arrested and charged with four counts of insurance fraud, perjury, and attempted perjury.

Richard Salas is a Deputy Public Defender with Los Angeles County. He alleged a work related injury due to emotional and psychological stress associated with his job. Salas has continued with this argument throughout various medical visits and under oath in deposition. Through County authorized private investigations, it was learned that Salas has been working as an attorney in private practice in Las Vegas, while trying to collect benefits in Los Angeles. When specifically asked about this during deposition and at Workers' Compensation Appeals Board hearing, Salas denied having any outside employment, despite evidence indicating otherwise.

Prosecuting Authority: Los Angeles County
Fraud Type: Claimant Fraud
Status: Pending

Rosa Pitones (06EW022569) – Rosa Cazares Pitones, 52, of Imperial Valley, was arraigned on April 9, 2009, on three counts of insurance fraud and one count of grand theft. Pitones was arrested on March 9, 2009.

On July 1, 2004, Pitones filed a workers' compensation injury claim with SCIF. The injury reportedly occurred while Pitones, a librarian at Centinela State Prison, was moving office furniture out of her work area. Pitones claimed to have shoulder and back pain and could not return to work at the prison due to the injury. Pitones was initially off work for approximately one year. In August 2006, she returned to work briefly before suffering a back injury, and reportedly unable to fulfill her duties as librarian. Witness statements reported that while on leave from Centinela State Prison, Pitones was receiving compensation while working as an assistant librarian at Imperial Valley College.

A joint investigation by CDI, the California Department of Corrections Office of Investigative Services and Office of Internal Affairs and the Imperial County District Attorney's Office revealed that Pitones was employed full-time as an assistant librarian with Imperial Valley College while she continued to receive workers' compensation payments totaling $20,617. As part of her claim, Pitones stated that she was unable to do the work of a Department of Corrections Librarian due to her injuries. She also made statements to her treating physician that she was not able to work while she was employed as a full-time librarian at the college.

Prosecuting Authority: Imperial County
Fraud Type: Claimant Fraud
Status: Pending

Sharon Moore (05BW022143) – On November 7, 2006, Sharon Moore surrendered to the San Francisco County Main jail pursuant to an arrest warrant and was charged with knowingly presenting a false insurance claim, presenting false or misleading statements in support of a claim, and grand theft.

In July 1998, Sharon Moore, a nurse case manager for CNA Insurance Company, was involved in an automobile accident with a third party vehicle and sustained neck and back strain. Moore filed a workers' compensation claim and began receiving benefits. In 2005, an adjuster received information that Moore was working as a nurse case manager for Intercorp, Inc., while still collecting benefits. Employment records were then subpoenaed from Intercorp, which revealed Moore was employed as a nurse case manager from August 2003 to June 2005.

Prosecuting Authority: San Francisco County
Fraud Type: Claimant Fraud
Conviction: On November 3, 2008, Moore was sentenced and convicted of six felony counts of insurance fraud and sentenced to 250 hrs of community service and five years felony probation. Moore was also ordered to pay $67,688 in restitution.

Donald Clark (07HW005362) – On June 25, 2009, Donald Clark was arrested and charged with grand theft, perjury, and presenting a knowingly false or fraudulent statement in support of a claim for compensation.

Donald Clark was hired on December 17, 2000 as a mechanics assistant for Schneider National, Inc. and in June 2001, Clark alleged a cumulative trauma injury to his upper extremities. He has been receiving Total Temporary Disability (TTD) benefits from December 25, 2003 to the present. A deposition has been taken since his reporting of the injury and Clark has denied being employed in his testimony under oath. Surveillance was conducted which showed him performing legal type duties at a Riverside courthouse and court records show Clark appeared as the Defense Attorney on an Unlawful Detainer case while collecting TTD benefits. In addition to the claimant appearing to work in a legal capacity, he was also observed conducting numerous strenuous activities with his upper extremities, including working on an engine, climbing onto a truck and throwing bales of hay.

Prosecuting Authority: San Bernardino County
Fraud Type: Claimant Fraud
Conviction: On August 10, 2009, Clark was sentenced to serve 5 days in county jail and three years probation. Clark was also ordered to pay $110 in restitution and $160 in criminal fines.

Stephanie Sargiotto (06BW019697) – On September 16, 2008, Stephanie Sargiotto was arrested on five counts of insurance fraud and one count of grand theft.

Stephanie Sargiotto sustained an injury to her arms while working for Nob Hill Foods. Cutis Moring Insurance Agency (CMI) administered Sargiotto's claim. She had numerous procedures/surgeries on her arms and collected temporary disability benefits through June 9, 2006 when she was deemed permanent and stationary. As early as January 2005, Sargiotto began working for Pamela Erb, doing business as Pam's Office Solutions. Sargiotto was paid every other week and an effort was made by Erb to

conceal Sargiotto's pay by issuing the paychecks to Sargiotto's husband, John. John Sargiotto lied to CDI Investigators when he reported that he worked for Erb for fourteen months and that Sargiotto never worked for Erb. CMI paid Stephanie Sargiotto approximately $25,000 in temporary disability benefits during the period January 25, 2005 through March 7, 2006.

Prosecuting Authority: Alameda County
Fraud Type: Claimant Fraud
Conviction: On September 16, 2008, Stephanie Sargiotto was convicted of one count of insurance fraud and sentenced to 15 days in county jail and three years probation. In addition, Sargiotto was ordered to pay $26,000 in restitution and $120 in criminal fines.

Preston Clayton (06AW010595) – On May 2, 2008, Preston Clayton of Yuba City was convicted of one count of grand theft for making false statements to obtain workers' compensation benefits.

Clayton alleged a right hand and wrist injury from performing repetitive tasks after being employed less than 2 weeks at Sutter County Public Works Department as a maintenance worker. Clayton was put on modified duty by physician's assistant at his examination, then a clinic doctor diagnosed wrist pain with symptom magnification during a second examination. Clayton never returned to work.

Clayton claimed in a deposition he was unable to use his right hand or wrist, however, video surveillance of Clayton a week prior to the deposition depicts him digging, cleaning a pool using his right hand, and working on a car engine using his wrist normally. Clayton denied in his deposition using his right hand or wrist to clean the pool and denied working on his vehicle other than to change brake pads. Clayton's physician was shown the video and stated if he had seen the video he would have placed Clayton on less restrictive modified duties.

Prosecuting Authority: Sutter County
Fraud Type: Claimant Fraud
Conviction: In February 2009, Preston Clayton was sentenced, to 30 days in county jail and three years probation. He was also ordered to pay $6,203 restitution and $200 in criminal fines.

Ronald Barsz (07HW000842) – On March 6, 2009, Ronald Barsz pled guilty to one count of insurance fraud, presenting a knowingly false or fraudulent statement in support of a claim for compensation.

Barsz, while employed as a customer service representative by the City of Hemet, reported suffering a back injury on January 7, 2006. During deposition and medical exams, he could not recall any previously reported back injuries. A CDI investigation discovered DMV records that reflected six prior traffic collision reports, in which Barsz reported suffering back injuries.

Prosecuting Authority: San Bernardino County
Fraud Type: Claimant Fraud

Conviction: March 6, 2009, Ronald Barsz pled guilty to one count of insurance fraud and sentenced to 60 days in county jail and three years probation. Barsz was also ordered to pay $12,000 in restitution.

Norman Anderson (03JW012296) – Norman Anderson was convicted on September 29, 2008 of two counts of insurance fraud.

Anderson sustained an industrial injury to his right hand, but had since misrepresented his disability based on surveillance and the medical reports of several doctors. On September 7, 2007, Anderson was arrested in Hawaii while working on his sailboat and extradited to Ventura County.

Prosecuting Authority: Ventura County
Fraud Type: Claimant Fraud
Conviction: On November 4, 2008, Norman Anderson was sentenced to two years in state prison and ordered to pay $97,425 in restitution and $400 in criminal fines.

4.) Suspected Fraudulent Claims (Calendar Years 2007 through 2009)

County	2007 SFCs	2008 SFCs	2009 SFCs	TOTAL
ALAMEDA	220	214	216	**650**
ALPINE	1			**1**
AMADOR	7	4	2	**13**
BUTTE	13	22	16	**51**
CA STATE ATTY GEN	1	2		**3**
CALAVERAS	6	6		**12**
COLUSA	1	3	3	**7**
CONTRA COSTA	139	105	119	**363**
DEL NORTE	3	2	3	**8**
EL DORADO	17	16	16	**49**
FRESNO	124	93	95	**312**
GLENN	3	5	1	**9**
HUMBOLDT	7	13	7	**27**
IMPERIAL	18	16	15	**49**
INYO	2	3		**5**
KERN	95	59	62	**216**
KINGS	17	17	19	**53**
LAKE	3	8	11	**22**
LASSEN	3	2	4	**9**
LOS ANGELES	1,620	1,783	1,704	**5,107**
MADERA	18	20	14	**52**
MARIN	20	25	28	**73**
MARIPOSA	1	1	1	**3**
MENDOCINO	7	14	10	**31**
MERCED	25	18	13	**56**
MODOC		2		**2**
MONO	1			**1**
MONTEREY	88	57	76	**221**
NAPA	17	27	17	**61**
NEVADA	7	9	5	**21**
ORANGE	385	524	404	**1,313**
PLACER	51	42	26	**119**
PLUMAS	4	3	3	**10**
RIVERSIDE	205	254	223	**682**
SACRAMENTO	159	123	121	**403**
SAN BENITO	7	6	6	**19**
SAN BERNARDINO	291	310	301	**902**
SAN DIEGO	379	393	269	**1,041**
SAN FRANCISCO	113	128	92	**333**
SAN JOAQUIN	75	60	41	**176**
SAN LUIS OBISPO	18	26	30	**74**
SAN MATEO	92	81	66	**239**
SANTA BARBARA	29	54	31	**114**

4.) Suspected Fraudulent Claims (Calendar Years 2007 through 2009)(Continued)

County	2007 SFCs	2008 SFCs	2009 SFCs	TOTAL
SANTA CLARA	269	184	153	**606**
SANTA CRUZ	39	29	40	**108**
SHASTA	33	42	12	**87**
SIERRA				**0**
SISKIYOU	3	6	2	**11**
SOLANO	52	51	35	**138**
SONOMA	63	65	51	**179**
STANISLAUS	51	53	29	**133**
SUTTER	11	6	9	**26**
TEHAMA	2	3	2	**7**
TRINITY	1		1	**2**
TULARE	41	41	27	**109**
TUOLUMNE	3	5	4	**12**
US ATTY CENTRAL CA			1	**1**
US ATTY NORTH CA				**0**
VENTURA	87	108	104	**299**
YOLO	24	29	16	**69**
YUBA	3	5	3	**11**
UNKNOWN	9	6		**15**
Grand Total	**4,983**	**5,183**	**4,559**	**14,725**

5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09)

Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
July 2008				
Benicia	07BW011833	BURRELL, MARVIN	07/29/08	ALAMEDA
Benicia	07BW010875	LYONS, JAMES	07/03/08	SOLANO
Sacramento	06AW016048	MOA, TEVITA	07/14/08	YOLO
Benicia	07BW014145	SALMERON, ANTONIO	07/03/08	CONTRA COSTA
Inland Empire	07HW011389	SERVIN, ROLANDO	07/08/08	RIVERSIDE
Benicia	05BW012173	SIERRA, MARY	07/24/08	ALAMEDA
Inland Empire	07HW018566	SUMPTER, CHARLENE	07/09/08	SAN BERNARDINO
Benicia	08BW005697	THOMAS, SUSAN	07/03/08	ALAMEDA
So. LA County	07CW008060	WHITE, JACQUELINE	07/10/08	LOS ANGELES
August 2008				
Benicia	08BW015578	ACOSTA, ABEL	08/28/08	ALAMEDA
Benicia	08BW015578	ALFARO, MARIO	08/27/08	ALAMEDA
San Diego	08EW015209	ALVA, MIKE	08/20/08	SAN DIEGO
Benicia	06BW018701	ALVAREZ, EDUARDO	08/01/08	ALAMEDA
Sacramento	07AW006530	ATKINSON, CURTIS	08/22/08	SHASTA
Benicia	08BW015578	AVINA, ESTEBAN	08/27/08	ALAMEDA
Benicia	08BW015578	BELKNAP, RODNEY	08/28/08	ALAMEDA
Benicia	08BW015578	BIERLY, MICHAEL	08/28/08	ALAMEDA
Benicia	08BW015578	CAMBERO, IGNACIO	08/27/08	ALAMEDA
Orange	07DW000558	CAMPBELL, ASIA	08/22/08	ORANGE
Benicia	08BW015578	CARRASCAL, SEGUNDO	08/28/08	ALAMEDA
Benicia	08BW015578	CASTREJON, PEDRO	08/28/08	ALAMEDA
Benicia	08BW015578	DOMINGUEZ, JAVIER	08/28/08	ALAMEDA
Benicia	06BW021099	DUPRET, MILES	08/15/08	SONOMA
Benicia	07BW005657	GARCIA III, MIGUEL	08/22/08	ALAMEDA
Benicia	08BW015578	GARCIA, JESUS	08/27/08	ALAMEDA
Benicia	08BW008430	GIMROTH, DAVID	08/21/08	SONOMA
Benicia	08BW015578	GONZALEZ, PEDRO	08/28/08	ALAMEDA
Silicon Valley	08GW015501	HARTING, SONYA	08/12/08	SANTA CRUZ
Benicia	08BW015578	HEGARDT, BRIAN	08/27/08	ALAMEDA
Silicon Valley	08GW015204	HO, LE	08/12/08	SANTA CRUZ
Silicon Valley	08GW015217	HO, LE	08/12/08	SANTA CRUZ
Benicia	08BW015578	HOYOS-LONDONO, OSCAR	08/28/08	ALAMEDA
Benicia	08BW015578	HUBBARD, PATRICK	08/27/08	ALAMEDA
Benicia	08BW015578	KOSTKA, MARIAN	08/27/08	ALAMEDA
Benicia	08BW015578	MAILE, ETUATE	08/27/08	ALAMEDA
Benicia	08BW015578	MELENDREZ, JAVIER	08/27/08	ALAMEDA
Benicia	08BW015578	MESUI, KAHO	08/28/08	ALAMEDA
Benicia	08BW015578	MOALA, TUUANG	08/27/08	ALAMEDA
Silicon Valley	08GW015502	NGUYEN, ETHAN	08/12/08	SANTA CRUZ
Benicia	08BW015578	NGUYEN, LE	08/27/08	ALAMEDA
Benicia	08BW015578	NGUYEN, THUAN	08/27/08	ALAMEDA
Silicon Valley	08GW015227	NGUYEN, VAN	08/13/08	SANTA CRUZ
Benicia	08BW013430	PUAMAU, MAILUA	08/27/08	CONTRA COSTA
Benicia	08BW015578	REGO, EUDES	08/28/08	ALAMEDA

5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09) (continued)

Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
August 2008				
Inland Empire	08HW000694	ROSSMAN, II, ROBERT	08/21/08	SAN BERNARDINO
Benicia	08BW015578	TOPETE, FRANCISCO	08/27/08	ALAMEDA
Benicia	08BW015578	VARGAS, JESUS	08/27/08	ALAMEDA
Benicia	08BW015578	WHETSTONE, RICHARD	08/28/08	ALAMEDA
Benicia	08BW015578	WHITEHEAD, GARY	08/28/08	ALAMEDA
Benicia	08BW015578	WIDGER, LARRY	08/28/08	ALAMEDA
September 2008				
Benicia	08BW008988	CARSON, TAMISHA	09/29/08	SOLANO
Benicia	09BW008762	CHANG, W	09/10/08	ALAMEDA
Inland Empire	07HW013425	GAMM, FRED	09/24/08	SAN BERNARDINO
Benicia	08BW022204	RAPISURA, ROBERT	09/23/08	ALAMEDA
Benicia	08BW022199	TASILA, TEVITA	09/11/08	CONTRA COSTA
October 2008				
Benicia	08BW020087	ALOFAKI, TITIANI	10/20/08	CONTRA COSTA
Orange	07DW018921	BELTRAN, ANTHONY	10/14/08	ORANGE
Inland Empire	08HW017140	BELVILLE, KEVIN	10/21/08	SAN BERNARDINO
Sacramento	08AW019059	BRICKER, MARK	10/15/08	YOLO
Inland Empire	08HW017140	CAPKA, CHRISTIAN	10/22/08	SAN BERNARDINO
Sacramento	08AW019059	CENTENO, JOSEPH	10/15/08	YOLO
Sacramento	08AW019059	COLE, MARTY	10/15/08	YOLO
Inland Empire	08HW003729	DE SALAS, CLAUDIA	10/15/08	SAN BERNARDINO
Sacramento	08AW019059	DEPELLO III, GENO	10/15/08	YOLO
Benicia	08BW005132	DEVITA, ROBERT	10/01/08	ALAMEDA
Inland Empire	08HW017140	ELIZARRARAS, JUAN	10/21/08	SAN BERNARDINO
Inland Empire	08HW015383	FLORES MORA, JESUS	10/20/08	SAN BERNARDINO
Inland Empire	08HW017140	GARCIA, JOSE	10/22/08	SAN BERNARDINO
Sacramento	08AW019059	GARCIA, KENNETH	10/15/08	YOLO
Inland Empire	08HW017140	HUBERTH, BRIAN	10/22/08	SAN BERNARDINO
Inland Empire	08HW017140	HYLAND, ROBERT	10/22/08	SAN BERNARDINO
San Diego	07EW019127	JOHNSON, GORDON	10/09/08	SAN DIEGO
Benicia	08BW007678	LEVYN, WILLIAM	10/16/08	CONTRA COSTA
Sacramento	08AW019059	LEWIS, RICK	10/15/08	YOLO
Sacramento	08AW019059	OSORIO JR, JOSE	10/15/08	YOLO
Inland Empire	08HW017140	PACE, PAUL	10/21/08	SAN BERNARDINO
Inland Empire	08HW017140	PALENCHAR, BRAD	10/21/08	SAN BERNARDINO
Sacramento	08AW019059	RIVERA, ESMELIN	10/15/08	YOLO
Inland Empire	08HW017140	ROCHA, ARTURO	10/21/08	SAN BERNARDINO
Sacramento	08AW019059	SANTOS, FRANCISCO	10/15/08	YOLO
Sacramento	08AW019059	SEIDEL III, BILLY	10/15/08	YOLO
Sacramento	08AW019059	SIN, DAU	10/15/08	YOLO
Inland Empire	08HW017140	SOTO, JAVIER	10/21/08	SAN BERNARDINO
Inland Empire	08HW017140	STONER, MATTHEW	10/22/08	SAN BERNARDINO
Inland Empire	08HW017140	VITORINO, NELSON	10/21/08	SAN BERNARDINO
Inland Empire	08HW017140	WARAPIUS, JESSE	10/21/08	SAN BERNARDINO
Inland Empire	08HW017140	WINTERS, GARY	10/22/08	SAN BERNARDINO

5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09) (continued)

Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
November 2008				
Inland Empire	07HW008395	ATLAS-HEARN, KINYA	11/21/08	SAN BERNARDINO
Benicia	08BW010411	BUSH, CHARLES	11/11/08	ALAMEDA
Sacramento	08AW000348	CANO VERDUZCO, BRIGIDO	11/14/08	SAN JOAQUIN
Benicia	08BW010951	CHEW, SUSON	11/06/08	MARIN
Benicia	08BW005086	CRUZ, JULIO	11/02/08	ALAMEDA
Benicia	08BW005697	EKMAN, LEONARD	11/07/08	ALAMEDA
Sacramento	08AW012689	HUSTRULID, WILLIAM	11/12/08	SACRAMENTO
Benicia	08BW021394	LUO, JIE	11/13/08	CONTRA COSTA
Inland Empire	08HW015847	MASSY, KUM	11/06/08	SAN BERNARDINO
Benicia	08BW010952	SINGH, JOGINDER	11/06/08	MARIN
So. LA County	05CW021578	TAI, DAVID	11/26/08	LOS ANGELES
Benicia	08BW020090	VAEA, ROBERT	11/13/08	CONTRA COSTA
Inland Empire	07HW012573	WELLS, CHEYNE	11/12/08	SAN BERNARDINO
So. LA County	05CW021578	ZAHLER, DAVID	11/26/08	LOS ANGELES
December 2008				
Benicia	08BW013587	CALDERON, JOSE	12/10/08	ALAMEDA
So. LA County	08CW000799	HERNANDEZ, NANCY	12/09/08	LOS ANGELES
Valencia	08JW008761	HERNANDEZ-GUTIERREZ, ALFREDO	12/30/08	VENTURA
Benicia	08BW020443	LINARES, JERRY	12/22/08	CONTRA COSTA
Sacramento	08AW002251	MACIEJEWSKI, DAVID	12/19/08	SAN JOAQUIN
So. LA County	08CW016963	MARTINEZ, RIGOBERTO	12/19/08	LOS ANGELES
Sacramento	08AW019786	RICHARDS, JIM	12/30/08	SAN JOAQUIN
Benicia	08BW020094	ROBIN, LUIS	12/05/08	CONTRA COSTA
Benicia	05BW019599	SCHILLINGER, MARK	12/12/08	MARIN
January 2009				
Benicia	08BW010953	AGHAZADEH, NIMA	01/29/09	MARIN
Inland Empire	08HW019296	BARDEN, LISA	01/29/09	RIVERSIDE
Silicon Valley	09GW002649	BUI, TOAN	01/20/09	MONTEREY
San Diego	07EW010470	CASTILLO, MIGUEL	01/23/09	SAN DIEGO
Orange	05DW018999	CORBIN, MICHAEL	01/12/09	ORANGE
So. LA County	08CW012868	DELGADILLO, HECTOR	01/16/09	LOS ANGELES
Sacramento	07AW021885	FERNANDEZ, RALPH	01/21/09	SAN JOAQUIN
Sacramento	08AW019059	GARCIA, ANTONIO	01/22/09	YOLO
Silicon Valley	09GW002673	GARNER, STEVEN	01/20/09	MONTEREY
Fresno	06FW015378	GONZALES, DOMINICK	01/16/09	KERN
Silicon Valley	09GW002674	JOHAI, MICHAEL	01/22/09	MONTEREY
Valencia	08JW010363	MAYER, WILLIAM	01/20/09	VENTURA
Silicon Valley	09GW002675	OH, MYONG	01/22/09	MONTEREY
San Diego	07EW011560	PAUL, PATRICK	01/22/09	SAN DIEGO
Fresno	08FW022782	RAMOS, CARL	01/01/09	KINGS
Inland Empire	07HW007619	STOWELL, KATHY	01/14/09	SAN BERNARDINO
February 2009				
Valencia	08JW010363	BILL MAYER SADDLES, INC.,	02/11/09	VENTURA
Valencia	07JW019163	LYNCH, CAMERON	02/23/09	SACRAMENTO

5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09) (continued)

Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
February 2009				
Valencia	08JW010363	MAYER, LAURA	02/11/09	VENTURA
Benicia	09BW015420	OFAHULU, PAULIASI	02/11/09	ALAMEDA
Benicia	05BW014783	PAREDES, ANNA	02/03/09	SONOMA
Benicia	08BW013860	RODRIGUEZ, ARMANDO	02/24/09	CONTRA COSTA
Valencia	08JW016548	ZURAWIK, RICHARD	02/24/09	VENTURA
Valencia	08JW016548	ZURAWIK, ROBERT	02/24/09	VENTURA
March 2009				
Benicia	09BW004534	ARCHUNDIA, ADDISON	03/10/09	CONTRA COSTA
Benicia	09BW005736	CHACON, JAVIER	03/11/09	CONTRA COSTA
Fresno	08FW022932	CORTEZ, JESSIE	03/10/09	KERN
Fresno	08FW022932	DIAZ, MARTIN	03/11/09	KERN
Benicia	09BW004534	DIAZ, ROBERTO	03/10/09	CONTRA COSTA
Benicia	09BW004534	DUARTE, LEANDRO	03/11/09	CONTRA COSTA
Benicia	09BW001239	FANGUPO, SIALE	03/25/09	CONTRA COSTA
Benicia	09BW004534	FRIAS, JOSE	03/10/09	CONTRA COSTA
Fresno	08FW022932	GONZALEZ, BENITO	03/10/09	KERN
Benicia	09BW004534	GONZALEZ, DAVID	03/10/09	CONTRA COSTA
Benicia	09BW004534	GONZALEZ, PABLO	03/11/09	CONTRA COSTA
Benicia	09BW004534	HARO, MIGUEL	03/10/09	CONTRA COSTA
Fresno	03FW003701	HEBERT, LORENE	03/06/09	MERCED
Fresno	08FW022932	HIDALGO, ANIBAL	03/10/09	KERN
Benicia	09BW004534	JUNIOR, TOMAR	03/11/09	CONTRA COSTA
Fresno	08FW022932	LABONTA, WESLEY	03/10/09	KERN
Benicia	09BW004534	LARANCH, ADAM	03/10/09	CONTRA COSTA
Benicia	09BW004534	LUCERO, JULIO	03/10/09	CONTRA COSTA
Benicia	09BW004534	LUJANO, RAUDEL	03/11/09	CONTRA COSTA
Benicia	09BW004534	LUNDGREN, ANTONIO	03/11/09	CONTRA COSTA
Fresno	03FW003701	LUNGREN, MARK	03/06/09	MERCED
Valencia	08JW010352	MA, THUAN	03/12/09	VENTURA
San Diego	08EW008103	MAHESHWARI, DEVDAT	03/22/09	SAN DIEGO
San Diego	08EW006766	MAHESHWARI, DEVDAT	03/22/09	SAN DIEGO
Benicia	07BW016433	MAZARIEGOS, DONAL	03/02/09	ALAMEDA
Benicia	09BW004534	MORALES/PULIDO, JOSE	03/11/09	CONTRA COSTA
Benicia	09BW004534	MORENO, SALVADOR	03/11/09	CONTRA COSTA
Benicia	09BW004534	NGUYEN, ALAN	03/10/09	CONTRA COSTA
Valencia	08JW010352	NGUYEN, THU	03/12/09	VENTURA
Benicia	08BW002502	OVERCASH, CASEY	03/18/09	ALAMEDA
Benicia	06BW008437	OWEN, JOHN	03/04/09	ALAMEDA
Benicia	06BW008437	OWEN, VIOLA	03/04/09	ALAMEDA
Benicia	09BW004534	PULIDO, ARTURO	03/11/09	CONTRA COSTA
Benicia	08BW006945	RAMIREZ, REMBERTO	03/24/09	ALAMEDA
Fresno	03FW003701	RICHARDS, RONALD	03/06/09	MERCED
Benicia	09BW004534	RODRIGUEZ, SALVADOR	03/11/09	CONTRA COSTA
Fresno	09FW005420	RODRIQUEZ, GEORGE	03/24/09	MADERA
Benicia	09BW004534	SANTIAGO, FORTUNADO	03/10/09	CONTRA COSTA
Fresno	03FW003701	SHEAFFER, WILLIAM	03/06/09	MERCED

5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09) (continued)

Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
March 2009				
Fresno	08FW022932	SOBALVARRO, CARLOS	03/10/09	KERN
Fresno	09FW005420	SONGU, CHARAN	03/24/09	MADERA
Benicia	09BW004534	STANLEY, RICHARD	03/11/09	CONTRA COSTA
Benicia	09BW004534	STANLEY, ZACHARIAH	03/11/09	CONTRA COSTA
So. LA County	08CW001674	TANAEIM, PEJMAN	03/26/09	LOS ANGELES
Valencia	08JW010352	THUAN THUY, INC.,	03/12/09	VENTURA
Benicia	09BW004534	TOLEDANO, FREDERICO	03/10/09	CONTRA COSTA
Fresno	08FW022932	TRUJILLO, RAMON	03/10/09	KERN
Benicia	09BW004534	VALDEZ, SERGIO	03/10/09	CONTRA COSTA
Fresno	08FW022932	VERGARA, ABDON	03/10/09	KERN
Benicia	09BW005019	VO, BINH	03/11/09	CONTRA COSTA
Fresno	03FW003701	WALKER, JASON	03/06/09	MERCED
April 2009				
Sacramento	08AW005088	BEARD, DAVID	04/23/09	SHASTA
Sacramento	08AW005088	BEARD, TIMOTHY	04/23/09	SHASTA
Silicon Valley	09GW006793	BITAR, MUSTAFA	04/03/09	MONTEREY
Valencia	07JW016836	DIAZ, NESTOR	04/23/09	LOS ANGELES
Silicon Valley	07GW000617	HAAS, KIMBERLY	04/29/09	SANTA CLARA
Silicon Valley	07GW000617	HAAS, SR, RONALD	04/29/09	SANTA CLARA
Orange	08DW001808	HANCOCK, BRETT	04/24/09	ORANGE
Benicia	09BW005851	HOANG, SANG	04/08/09	CONTRA COSTA
Orange	06DW021975	KILE, DEVON	04/29/09	ORANGE
Valencia	06JW004824	KIM, ANDREW	04/15/09	LOS ANGELES
So. LA County	09CW006670	MARTINEZ, RIGOBERTO	04/10/09	LOS ANGELES
So. LA County	08CW004202	OROPEZA ROBLES, JOSE	04/02/09	LOS ANGELES
Orange	06DW021975	PETRONELLA, MICHAEL	04/29/09	ORANGE
Benicia	07BW011171	POUYA, VILDA	04/02/09	CONTRA COSTA
Benicia	09BW000548	RADDOHL, VICKI	04/14/09	MARIN
San Diego	07EW011541	RAYAS, JESUS	04/14/09	SAN DIEGO
So. LA County	08CW019129	VENTURA, ARMANDO	04/17/09	LOS ANGELES
Orange	08DW024246	VILCHIS, SABINO	04/29/09	ORANGE
Valencia	06JW004824	YANG, CHAN	04/15/09	LOS ANGELES
May 2009				
Inland Empire	08HW019293	CARPENTER, LATANYA	05/06/09	LOS ANGELES
Fresno	09FW010781	GARCIA - CHAVEZ, JORGE	05/27/09	KERN
Inland Empire	09HW005855	MARTINEZ, GEORGE	05/06/09	SAN BERNARDINO
Inland Empire	09HW005855	PORRATA, HECTOR	05/06/09	SAN BERNARDINO
Benicia	08BW016055	RESENDIZ, MARCO	05/12/09	ALAMEDA
Benicia	05BW017902	RUAN, JOEY	05/26/09	ALAMEDA
So. LA County	08CW021765	SALAS, RICHARD	05/13/09	LOS ANGELES
Inland Empire	09HW005855	THOMPSON, CARA	05/06/09	SAN BERNARDINO
Benicia	05BW017902	WU, TIN	05/26/09	ALAMEDA
San Diego	06EW013640	ZIMMERMAN, NICHOLAS	05/11/09	SAN DIEGO
June 2009				
Inland Empire	07HW005362	CLARK, DONALD	06/25/09	SAN BERNARDINO

5.) Workers' Compensation Fraud Arrests (Fiscal Year 2008-09) (continued)

Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
June 2009				
Inland Empire	09HW008511	GHARABETY, SEYED	06/25/09	SAN BERNARDINO
Benicia	09BW013459	HALL, JASON	06/25/09	CONTRA COSTA
Inland Empire	09HW008511	MOTTAGHI, EZZATOLLA	06/25/09	SAN BERNARDINO
Sacramento	09AW000132	TARANTINO, CHERYL	06/13/09	SACRAMENTO
Fresno	07FW008442	XAVIER, CONSTANTINO	06/11/09	MERCED

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Alameda					
411544	Alvarez, Eduardo	Claimant Fraud	1 day(s) jail 36 month(s) probation	$12,933	$100
128892	Avina, Estaban	Uninsured Employer	1 day(s) jail 18 month(s) probation		$500
128940	Belknap, Rodney	Uninsured Employer	1 day(s) jail 36 month(s) probation		$1,000
H46976	Bonilla, Marcos	Claimant Fraud	180 day(s) jail 60 month(s) probation	$1,000	$200
161142	Bush, Charles	Claimant Fraud	30 day(s) jail 60 month(s) probation	$1,000	
H47148	Calderon, Jose	Claimant Fraud	16 day(s) jail 60 month(s) probation	$1,000	
128945	Cambero, Ignacio Velasquez	Claimant Fraud	1 day(s) jail 18 month(s) probation	$500	$345
128941	Castrejon, Pedro	Uninsured Employer	1 day(s) jail 12 month(s) probation		$500
543414	Chang, W Hugh	Claimant Fraud	1 day(s) jail 36 month(s) probation		
414415	Cruz, Julio	Claimant Fraud	2 day(s) jail 36 month(s) probation	$5,188	$120
H46080	Evans, Rodney	Claimant Fraud	4 day(s) jail 60 month(s) probation		
407329	Fisiiahi, Sione	Uninsured Employer	58 day(s) jail 36 month(s) probation		$1,600
H46195	Garcia, Miguel	Claimant Fraud	5 day(s) jail 60 month(s) probation		$1,000
161050	Hallgren, Gregory	Claimant Fraud	1 day(s) jail 60 month(s) probation	$96,000	
128947	Hegart, Brian	Uninsured Employer	1 day(s) jail 12 month(s) probation	$500	$345
128951	Hubbard, Patrick	Other			$250
406456	Lang, Tania	Claimant Fraud	1 day(s) jail 36 month(s) probation	$12,503	$120
128952	Maile, Etuate	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$345
128893	Maruicio, Oscar	Uninsured Employer	10 day(s) jail 36 month(s) probation		$1,500
H46488	Mazariego, Donal	Claimant Fraud	55 day(s) jail 60 month(s) probation		
227742	Mcclure, Dustin Keith	Uninsured Employer	6 day(s) jail 36 month(s) probation	$21,000	
128948	Melendrez, Javier Ruiz	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	
128894	Moala, Tuuanga	Claimant Fraud	1 day(s) jail 36 month(s) probation	$3,000	
413514	Negrete, Eli	Uninsured Employer	1 day(s) jail 36 month(s) probation	$7,500	$1,000
128954	Nguyen, Le Thanh	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
128953	Nguyen, Thuan	Uninsured Employer	1 day(s) jail 12 month(s) probation	$500	$245

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Alameda					
129567	Ofahulu, Pauliasi	Claimant Fraud	90 day(s) jail 36 month(s) probation	$9,080	
H46558	Overcash, Casey	Claimant Fraud	1 day(s) jail 60 month(s) probation	$2,978	$1,000
410402	Rapisura, Robert	Other	6 day(s) jail 36 month(s) probation	$2,801	$12,000
H45339	Sargiotto, Stephanie	Claimant Fraud	15 day(s) jail 60 month(s) probation		$1,000
84505	Scott, Steven	Claimant Fraud	1 day(s) jail 36 month(s) probation	$17,678	$100
410860	Sierra, Mary	Claimant Fraud	7 day(s) jail 60 month(s) probation		$1,000
410453	Sweetwyne, Kermit	Claimant Fraud	3 day(s) jail 36 month(s) probation	$5,000	$1,000
385841	Tafengatoto, Sione	Uninsured Employer		$12,100	
128895	Topete, Francisco	Other	1 day(s) jail 18 month(s) probation	$500	$345
128943	Vargas, Jesus	Uninsured Employer	1 day(s) jail 36 month(s) probation	$3,000	
128944	Whetstone, Richard	Claimant Fraud	24 month(s) probation	$500	$345
155551	Whitmeyer, Larry	Claimant Fraud	60 day(s) jail 36 month(s) probation		
Amador					
62-84399	Covert, Richard James	Uninsured Employer	12 month(s) probation	$100	$1,270
08CR14866	Maita, Joseph	Claimant Fraud	40 day(s) jail 36 month(s) probation	$3,000	$620
62-79134	Marchese, Alan	Uninsured Employer	12 month(s) probation	$100	$2,520
62-79935	O'Donnell, Gloria May	Claimant Fraud	30 day(s) jail 36 month(s) probation	$1,500	$500
08CR14131	Pechette, Joseph Lee	Premium Fraud	12 month(s) probation	$100	$2,120
Contra Costa					
2-298624-8	Algnarazi, Faiz	Uninsured Employer	12 month(s) probation		$1,120
1-139814-8	Alofaki, Titiani	Uninsured Employer	36 month(s) probation		$4,700
1-131125-7	Angles, John	Claimant Fraud	1 day(s) jail 60 month(s) probation 250 hour(s) community service.	$16,500	$220
1-142564-4	Hoang, Sang Thanh	Uninsured Employer	12 month(s) probation		$650
5-071861-9	Holani, Tuisila	Uninsured Employer	60 day(s) jail 36 month(s) probation		$100
4-160052-7	Linares, Jerry / Linares' Handyman	Uninsured Employer	26 day(s) jail 36 month(s) probation	$1,700	$250

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Contra Costa					
1-136857-0	Puamau, Mailau	Uninsured Employer	36 month(s) probation 100 hour(s) community service		$240
2-301438-8	Rodriguez, Armando	Uninsured Employer	24 month(s) probation		$2,620
5-070714-1	Sandoval-Muro, Daniel	Claimant Fraud	9 day(s) jail 36 month(s) probation	$4,406	$200
1-129778-7	Tasilia, Tevita	Claimant Fraud	90 day(s) jail 36 month(s) probation	$14,300	$100
1-140108-2	Vaea, Robert	Claimant Fraud	24 month(s) probation 80 hour(s) community service		$160
1-132841-1	Vaea, Siali	Uninsured Employer	36 month(s) probation 80 hour(s) community service		$120
1-136817-4	Vasquez, Concepcion	Uninsured Employer	12 month(s) probation		$1,120
El Dorado					
S06CRF0132	Beaver, Nicholas Jason	Claimant Fraud	365 day(s) jail 60 month(s) probation	$44,356	$5,140
P08CRM0045	Billings, Mark Robert	Uninsured Employer	36 month(s) probation		
P08CRM0641	Briggs, Larry Todd	Other	36 month(s) probation		$100
P08CRM0880	Buckley, Denis Walker	Other	24 month(s) probation		
P08CRM8382	Bussard, Kevin Todd	Other	12 month(s) probation		
P09CRM0163	Del Carlo, Frank	Other	12 month(s) probation		
P07CRF0246	Jones, Terry Loh	Claimant Fraud	24 month(s) probation	$32,000	$200
P07CRF0310	Killion, Steven Ray / Rossier Home Restoration	Uninsured Employer	18 month(s) probation		$200
P07CRF0476	Kruska, Dragoslav	Other	120 day(s) jail 48 month(s) probation	$5,000	
P08CRM0650	Magana, Humberto Anaya	Other	36 month(s) probation		$1,870
P08CRM1374	Mejia, Fernando / Cameron Park Remodel	Uninsured Employer	36 month(s) probation		
P08CRM0639	Nelson, Ronald Gerald	Other	36 month(s) probation		$500
P08CRM0634	Olson, Clinton	Uninsured Employer	24 month(s) probation		$955
P08CRM0643	Powers, Michael James	Uninsured Employer	36 month(s) probation		

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
El Dorado					
P08CRM0638	Robertson, James Edward	Other	24 month(s) probation		
P08CRF0427	Seo, Una	Premium Fraud	36 month(s) probation		$2,015
P08CRM1053	Smith, Garrett Duane	Uninsured Employer	24 month(s) probation		
P08CRM0649	Smith, James	Other	24 month(s) probation		$1,780
P07CRM1740	Vice, Curtis Edward	Uninsured Employer	24 month(s) probation		$120
P08CRM0637	Williams, Michael Ray	Other	36 month(s) probation		
Fresno					
08-42383	Alcala, Ramon	Claimant Fraud	12 month(s) probation	$1,000	
08-05017	Blanton, Trenton	Claimant Fraud	99 day(s) jail 60 month(s) probation	$14,823	$200
08-06539	Brown, Lupe Frausto	Claimant Fraud	365 day(s) jail 24 month(s) probation 365 days jail (stayed)	$15,000	$500
09-06605	Davis, Quirt	Other	36 month(s) probation	$5,000	
08-02664	Durazo, Alphonso Felix	Claimant Fraud	24 month(s) probation	$5,000	$550
08-45446	Garcia, Jose Olivio Ortiz	Uninsured Employer	12 month(s) probation	$1,500	
08-02666	Garcia, Ramon	Claimant Fraud	36 month(s) probation	$20,000	
08-45452	Gomez-Mancilla, Miguel A	Uninsured Employer	12 month(s) probation	$1,500	
08-45443	Haro, Santiago Reyes	Uninsured Employer	12 month(s) probation	$1,500	
07-27733	Juarez-Martinez, Agustin	Claimant Fraud	12 month(s) probation 100 hour(s) community service	$500	
08-28246	Lake, Wesley	Claimant Fraud	1 day(s) jail 24 month(s) probation	$5,637	$500
09-00133	Lillie, John	Uninsured Employer	12 month(s) probation	$1,000	
06-35453	Linares, Jamie	Claimant Fraud	12 month(s) probation 100 hour(s) community service		
08-06564	Loy, Helen	Claimant Fraud	36 month(s) probation	$12,000	$500
09-10843	Muna, Deana	Uninsured Employer	12 month(s) probation	$2,000	
05-36845	Nakata, Mark	Uninsured Employer	12 month(s) probation	$16,015	

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Fresno					
08-45448	Reyes, Eustorgio Cruz	Uninsured Employer	12 month(s) probation	$1,500	
08-06543	Reynolds, Chris	Claimant Fraud	36 month(s) probation 160 hour(s) community service		
07-13053	Rios, Armando David	Claimant Fraud	36 month(s) probation	$650,000	
08-42385	Rodriguez, Esteban	Uninsured Employer	12 month(s) probation	$2,000	
09-03058	Sherman, William	Claimant Fraud	16 month(s) prison	$18,000	$500
08-25882	Sihota, Kirpal Singh	Uninsured Employer	12 month(s) probation	$22,000	
09-07789	Taylor, Michele	Claimant Fraud	36 month(s) probation 50 hour(s) community service	$15,000	$450
09-04322	Tellez, Juan	Claimant Fraud	36 month(s) probation	$5,917	
08-45440	Torres, Carlos	Uninsured Employer	12 month(s) probation	$1,500	
09-09073	Wells, William	Uninsured Employer	12 month(s) probation	$1,000	
Humboldt					
WC08-0003	Hernandez, Cosme Sanchez / Humboldt Performance Experts	Claimant Fraud	48 month(s) probation		$320
Kern					
BF 120831C	Bayird, Barbara	Claimant Fraud	6 day(s) jail 36 month(s) probation 200 hour(s) community service	$21,400	
BM 749673A	Bragg, James Lee	Other	5 day(s) jail 36 month(s) probation		$865
BM 749682A	Brandvig, Gregory Paul	Other	5 day(s) jail 36 month(s) probation		$865
BM749688A	Bugarin, Miguel	Other	5 day(s) jail 36 month(s) probation		$865
BM749687A	Carrillo, Salomon	Other	5 day(s) jail 36 month(s) probation		$865
BM749689	Chavez, Gustavo	Other	5 day(s) jail 36 month(s) probation		$865
BM749675	Diaz, Martin	Uninsured Employer	10 day(s) jail 36 month(s) probation		$865
BM749671A	Gomez, Jose Alfredo	Other	5 day(s) jail 36 month(s) probation		$865
BM 749681A	Gonzalez, Benito	Uninsured Employer	10 day(s) jail 36 month(s) probation		$865

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Kern					
BM 745508A	Gonzalez, Dominik D	Premium Fraud	36 month(s) probation 50 hour(s) community service	$19,441	$365
BM749671A	Gonzalez, Jose Garcia	Other	5 day(s) jail 36 month(s) probation		$865
BF126463A	Gottwald, Thomas	Claimant Fraud	120 day(s) jail 36 month(s) probation 400 hour(s) community service	$30,000	$650
BM 749649A	Guitterez, Jesse Cortez	Uninsured Employer	15 day(s) jail 36 month(s) probation		$865
BM749668A	Hernandez, Andres Flores	Other	5 day(s) jail 36 month(s) probation		$865
BM749670A	Hernandez, Medardo Saucedo	Other	5 day(s) jail 36 month(s) probation		$865
BM749677A	Hidalgo, Lener Anibal	Uninsured Employer	10 day(s) jail 36 month(s) probation		$969
BF123885A	Kosich-enko, Svetlana	Single Entity Provider Fraud	16 month(s) prison		
BM749680A	Labonte, Wesley Steven	Other	5 day(s) jail 36 month(s) probation		$865
BM 749679A	Manning, Jason Anthony	Other	5 day(s) jail 36 month(s) probation		$865
BM749686A	Recinos, Victor Alfredo San Jose	Other	5 day(s) jail 36 month(s) probation		$865
BM749687A	Rodriguez, Daniel Leon	Other	5 day(s) jail 36 month(s) probation		$865
BM749684A	Sandoval, Eduardo Salazar	Other	5 day(s) jail 36 month(s) probation		$865
BM749678a	Sobalvarro, Carlos Joe	Uninsured Employer	10 day(s) jail 36 month(s) probation		$865
BM749690A	Trujillo, Ramon Heredia	Uninsured Employer	10 day(s) jail 36 month(s) probation		$4,500
Los Angeles					
BA336535	Acosta, Lauren A. / Bebe Inc.	Claimant Fraud	36 month(s) probation 50 hour(s) community service	$2,483	$100
BA338495	Aguilar, Victor M.	Claimant Fraud	1 day(s) jail 60 month(s) probation 100 hour(s) community service	$9,000	$693
BA337732	Ahumada, Maria / Seasons At Encino	Claimant Fraud	3 day(s) jail 60 month(s) probation 150 hour(s) community service	$31,854	$220
BA348165	Aldridge, Arnulfo / Mta	Claimant Fraud	24 month(s) probation		$120

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Los Angeles					
BA328933	Bakhyt, Said M. / Platinum Security	Claimant Fraud	36 month(s) probation 134 hour(s) community service	$5,000	$120
BA336238	Bartlett, Wynn / Long Beach USD	Claimant Fraud	1 day(s) jail 36 month(s) probation 100 hour(s) community service	$10,000	$693
BA337285	Benveniste, Michael I. / LAUSD	Claimant Fraud	36 month(s) probation 100 hour(s) community service	$439	$200
BA323780	Brunt, Norberto	Premium Fraud	118 day(s) jail 36 month(s) probation	$2,327,444	$200
BA318310	Bucknor, Wesley N.	Claimant Fraud	3 day(s) jail 36 month(s) probation	$25,000	$120
BA338660	Burtch, Cardella L.	Multiple Entities Provider Fraud	175 hour(s) community service	$2,500	
BA338660	Burthch, Daneen J.	Multiple Entities Provider Fraud	175 hour(s) community service	$2,500	$200
BA338945	Covarrubias, Pedro / Universal Molding Company	Claimant Fraud	36 month(s) probation	$5,000	$693
BA338888	Diaz, Jose Cruz / Golden Eagle Services	Claimant Fraud	60 month(s) probation 300 hour(s) community service	$20,000	$250
BA354114	Diaz, Nestor A. / Staff Chex	Claimant Fraud	24 day(s) jail 60 month(s) probation	$9,844	$250
BA334807	Fenstermacher Jr., Carl Henry / City Of Los Angeles	Claimant Fraud	2 day(s) jail 36 month(s) probation	$5,111	$220
BA337850	Garcia, Jose Luis / F. Rodgers Corp.	Claimant Fraud	70 day(s) jail 36 month(s) prison	$82,554	$1,200
BA318416	Goldenberg, Michail	Claimant Fraud	36 month(s) probation	$3,204	$165
BA337216	Gomez, Roxana	Claimant Fraud	90 day(s) jail 60 month(s) probation	$62,000	$320
9WA10175	Hong, Soon Eui / O-Shun Sushi Restaurant	Uninsured Employer	36 month(s) probation		$3,500
BA349548	Hwang, Jual Su	Premium Fraud	60 month(s) probation 100 hour(s) community service	$207,078	$200
BA349548	Hwang, Young Sue	Premium Fraud	60 month(s) probation 100 hour(s) community service		$200

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Los Angeles					
9WA10135	Ingistov, Alexander / Vinny's Pizza	Uninsured Employer	36 month(s) probation		$3,500
BA349358	Jeong, Byeong Uk / Grace Building Maintenance Company	Premium Fraud	180 day(s) jail 60 month(s) probation	$300,000	$260
BA338843	Kim, Kyung Soo	Premium Fraud	90 day(s) jail 36 month(s) probation	$89,335	$200
9BF00834	Kim, Sandy Soyon	Uninsured Employer	36 month(s) probation		$3,990
9BF01117	Koka, Venkatesh / Realty Specialty	Uninsured Employer	36 month(s) probation		$3,900
BA338298	Leon, Carl A. / LAUSD	Claimant Fraud	18 day(s) jail 60 month(s) probation 360 hour(s) community service	$69,897	$220
BA332385	Lepe, Jorge / Antelope Valley USD	Claimant Fraud	120 day(s) jail 60 month(s) probation		$120
BA333675	Linares, Jesus / Sysco Food Services	Claimant Fraud	1 day(s) jail 36 month(s) probation 150 hour(s) community service	$5,819	$200
BA333307	Lopez, Gabriel Rodriguez / Corporate Personnel Network	Claimant Fraud	2 day(s) jail 60 month(s) probation 150 hour(s) community service	$995	$220
9WA10170	Lopez, Valarie R. / Mandy's Family Restaurant	Uninsured Employer	36 month(s) probation		$3,500
BA232031	Mancini, Michael V.	Claimant Fraud	36 month(s) probation	$1,985	
BA351253	Mangel, Cyndi / Acer Mechanical Systems	Claimant Fraud	120 day(s) jail 60 month(s) probation 120 hour(s) community service	$67,200	$220
BA332465	Mansury, Toba / Glendale Adventist Medical Center	Claimant Fraud	1 day(s) jail 60 month(s) probation 250 hour(s) community service	$35,000	$693
BA332569	Martinez, Eduardo	Claimant Fraud	60 month(s) probation 300 hour(s) community service	$9,995	$200
BA350313	Martinez, Rigoberto R. / Majestic Insurance	Claimant Fraud	6 day(s) jail 60 month(s) probation 200 hour(s) community service	$2,757	$230

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Los Angeles					
BA355176	Martinez, Robert	Other	365 day(s) jail 60 month(s) probation	$7,219	$250
BA316667	Meugniot, Joseph	Premium Fraud	1 day(s) jail 24 month(s) probation	$10,000	$346
BA338660	Mike, Alesia A.	Multiple Entities Provider Fraud	90 day(s) jail 200 hour(s) community service	$4,000	$200
9BF00835	Murguia, Sotero / Artesia Center Cleaners	Uninsured Employer	36 month(s) probation		$3,990
BA330337	Navaei, Hossein / Indigo Hotel Investments, LLC	Claimant Fraud	120 day(s) jail 60 month(s) probation	$6,200	$700
BA338923	Ortiz Jr., Raymond / Hanson Distributing Company	Claimant Fraud	3 day(s) jail 36 month(s) probation 100 hour(s) community service		$220
BA337987	Preza, Louis J. / City Of Burbank	Claimant Fraud	120 day(s) jail 60 month(s) probation 360 hour(s) community service		$5,000
BA352382	Rangel, Gloria	Claimant Fraud	3 day(s) jail 60 month(s) probation 200 hour(s) community service	$6,444	$250
LA056935	Reyes Jr., Basilio Vizmonte	Other	84 month(s) prison	$646,458	$200
BA338968	Roberts, Derrick / Starbucks	Claimant Fraud	60 month(s) probation 200 hour(s) community service	$40,952	$220
BA336876	Rojas, Maria D. / Integrated Medical Management	Claimant Fraud	2 day(s) jail 60 month(s) probation 200 hour(s) community service	$10,000	$220
BA336240	Sandi, Thomas F. / Compass Group	Claimant Fraud	1 day(s) jail 60 month(s) probation 150 hour(s) community service	$15,500	$250
BA338825	Santa Cruz, Uver / Matrix Industries Inc.	Claimant Fraud	365 day(s) jail 60 month(s) probation 250 hour(s) community service	$8,555	$200
BA338910	Savella, Constancia S. / Palmdale USD	Premium Fraud	36 month(s) probation	$80,580	$693

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Los Angeles					
BA338967	Sawaed, Adel / Saward Title & Marble Installation	Premium Fraud	1 day(s) jail 60 month(s) probation 50 hour(s) community service	$50,000	$200
BA338967	Sawaed, Sawaed H. / Saward Title & Marble Installation	Premium Fraud	1 day(s) jail 60 month(s) probation 50 hour(s) community service	$50,000	$200
BA335462	Service Inc., Secured Shuttle / Secured Shuttle Service Inc	Premium Fraud	60 month(s) probation	$325,000	$693
9BF00836	Sizar, Tahir Mehdi / Mehfi Restaurant	Uninsured Employer	36 month(s) probation		$3,990
BA338814	Smith, Martha	Claimant Fraud	2 day(s) jail 36 month(s) probation 50 hour(s) community service	$2,500	$135
BA338631	Surovik, Connie / Palmdale USD	Claimant Fraud	60 month(s) probation 150 hour(s) community service	$85,000	$200
BA320741	Sykes, Kelron P.	Claimant Fraud	1 day(s) jail		
BA352992	Tanaeim, Pejman	Other	1 day(s) jail	$9,985	$260
BA338675	Tarana, Ronald / The Bedford Group	Claimant Fraud	60 month(s) probation 200 hour(s) community service	$47,962	$200
9WA10133	Torres, Sergio / Eagle Cleaners	Uninsured Employer	36 month(s) probation		$3,795
BA336753	Tucker, Kyle A. / Intensive Renal Care	Claimant Fraud	1 day(s) jail 60 month(s) probation 100 hour(s) community service	$5,000	$200
BA352785	Unger, Cathy Lynn / Cal Trans	Claimant Fraud	21 day(s) jail 60 month(s) probation 200 hour(s) community service	$32,885	$683
BA207716	Valenzuela, Humberto	Claimant Fraud	365 day(s) jail 60 month(s) probation	$1,985	
9WA10134	Ventura, Erick R. / Expert Cleaners	Uninsured Employer	36 month(s) probation		$3,500
BA328575	Vilanova, Oscar	Claimant Fraud	25 day(s) jail 250 hour(s) community service	$5,000	$693

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Los Angeles					
BA348326	Wilson, James A. / Los Angeles Unified School District	Claimant Fraud	56 month(s) prison	$416,000	$2,000
BA333109	Yeom, Jam Chang	Insider Fraud	180 day(s) jail 60 month(s) probation	$23,729	$693
BA338853	Zaragoza, Juan T. / Bothwell Automotive	Claimant Fraud	60 month(s) probation 200 hour(s) community service	$59,000	$250
Marin					
CR161443	Singh, Joginder / Dandy Market	Uninsured Employer	24 month(s) probation 30 hour(s) community service	$1,500	
Merced					
29834A	Aguilar, John / Foster Farms/AAA	Multiple Entities Provider Fraud	36 month(s) probation 100 hour(s) community service 6 mos. prob. suspended		$572
MF41863	Calderon, Jose	Claimant Fraud	36 month(s) probation	$6,550	$420
MM206323	Chavez, Alberto / Liberty Mutual	Claimant Fraud	36 month(s) probation 120 hour(s) community service	$5,000	
29834B	Delavara, Juan / Foster Farms/AAA	Multiple Entities Provider Fraud	36 month(s) probation 4 mos. County Jail suspended		$540
MF44834	Jimenez, Adrian / SCIF	Premium Fraud	180 day(s) jail 36 month(s) probation	$240,698	$1,072
MM208407	Reyes, Virginia / SCIF	Other	36 month(s) probation		$1,120
29834E	Saephan, Scott / Foster Farms/AAA	Multiple Entities Provider Fraud	36 month(s) probation 360 days County Jail suspended		$572
29834F	Thao, Ngia / Foster Farms/AAA	Multiple Entities Provider Fraud	36 month(s) probation 120 hour(s) community service Rest. reserved		$200
29834C	Van Dao, Ngoan / Foster Farms/AAA	Multiple Entities Provider Fraud	24 month(s) probation 180 days jail suspended		$245
29834D	Vang, Thomas / Foster Farms/AAA	Multiple Entities Provider Fraud	24 month(s) probation 180 days County Jail suspended	$100	$145
Monterey					
WCF08-0027	Almasi, Azita / Amerigas 76	Uninsured Employer	1 day(s) jail 36 month(s) probation		$10,120
WCF09-0046	Johai, Michael / Marina Handyman Services	Uninsured Employer	1 day(s) jail 36 month(s) probation		$10,000

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Monterey					
WCF09-0047	Oh, Nyong Jo / Young's Carpet Cleaning	Uninsured Employer	1 day(s) jail 36 month(s) probation		$10,000
Orange					
08CF1720	Avila, Martin	Claimant Fraud	36 month(s) probation		$100
08CM11097	Bun, Ketsangva / Sunshine Donuts	Uninsured Employer	36 month(s) probation		$10,100
08CF2304	Campbell, Asia	Claimant Fraud	36 month(s) probation		$200
08CM05148	Chalkan, Mark / Thai Princess Restaurant	Uninsured Employer	36 month(s) probation		$10,100
08CM12461	Chann, Annie / Sam's Donuts	Uninsured Employer			$100
08CM10774	Chau, Vann / Grandy's Donuts	Uninsured Employer		$300	$100
08CF3499	De Tar, Sally	Claimant Fraud	36 month(s) probation		$1,000
08CM09643	Deganis, Aldo / Aldo's Sidewalk Café	Uninsured Employer			$200
07CF3986	Estrada, Juanita	Claimant Fraud	120 day(s) jail 36 month(s) probation	$27,817	$700
08CF1721	Figueroa, Martha	Claimant Fraud	36 month(s) probation		$100
08CF2303	Frampton, Tracy	Claimant Fraud	12 month(s) probation		$600
07CF1230	Gall, D.c., Randall	Single Entity Provider Fraud	12 month(s) probation	$940	$5,100
08CM12459	Haro-Funes, Eva / Sweet Heaven Bakery	Uninsured Employer			$400
08CM09916	Hernandez, Efrain / Anaheim Circuit Breakers	Uninsured Employer		$300	$100
09CM02458	Kim, Leang / K's Donuts	Uninsured Employer			$400
08CM11148	Kong, Billy / Balboa Bakery & Donuts	Uninsured Employer			$300
08CM09649	Lee, Jong / Crown Cleaners	Uninsured Employer	36 month(s) probation		$10,100
08CM08354	Lee, Seo	Uninsured Employer	36 month(s) probation		$10,100
08CM09648	Lee, Sun / Jax Donuts	Uninsured Employer	36 month(s) probation		$10,100

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Orange					
09CM00639	Lim, Yoon / Tiffany Knit	Uninsured Employer	36 month(s) probation		$10,100
08CF0612	Maclellan, Maureen	Claimant Fraud	36 month(s) probation	$87,760	$200
08CM13853	Marta, Chad / Curves For Women	Uninsured Employer	36 month(s) probation		$10,100
08CM13853	Marta, Sadie Jean / Curves For Women	Uninsured Employer	36 month(s) probation		$10,100
08CF1235	Medina, Anthony / Prompt Insurance Agency	Insider Fraud	120 month(s) prison	$2,599,402	$200
09CM01246	Metro, Stephen / Oh Those Donuts	Uninsured Employer			$400
09CM01243	Nam, Jackie / South Swell Donuts	Uninsured Employer	36 month(s) probation		$10,100
08CM09644	Patel, Ghanshyam / Huntington Beach Smoke Shop	Uninsured Employer	36 month(s) probation		$10,100
08CM08355	Shinn, Young / One Hour Valetone Cleaners	Uninsured Employer	36 month(s) probation		$10,100
09CM01244	Simidian Ii, Vahan / Paramount Tennis	Uninsured Employer			$400
08CM08175	Srey, Dyvan / Country Club Donuts	Uninsured Employer			$300
08CM09647	Teav, Tom / La Habra Donut Shop	Uninsured Employer	36 month(s) probation		$10,100
08CM12294	Tran , Timothy Tuan/ Rick's 24 Hour Cleaners	Uninsured Employer			$100
08CM10480	You, Serey / Makers Donuts	Uninsured Employer		$300	$100
Riverside					
RIM 517858	Alvarez, Flavio Vallejo	Uninsured Employer	36 month(s) probation	$125	$55
RIM 533720	Bean, Stanley Clyde	Uninsured Employer	36 month(s) probation	$125	$1,130

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Riverside					
RIM 531135	Beltran, Christopher Ochoa	Uninsured Employer	36 month(s) probation	$125	$1,055
INM 19006	Betancourt, Ernesto	Uninsured Employer			$555
RIM 533748	Bhaghani, Yousef Ahmed	Uninsured Employer	36 month(s) probation		$565
RIM 535177	Bonilla, Emilio Isais	Uninsured Employer	36 month(s) probation	$125	$1,050
RIF 136046	Bowen, Douglas Wayne	Premium Fraud	60 day(s) jail 36 month(s) probation	$55,621	$255
RIF 143676	Cashman, James	Premium Fraud	60 day(s) jail 36 month(s) probation	$557,634	$235
RIF 143676	Cashman, Kevin John	Premium Fraud	14 day(s) jail 36 month(s) probation		$155
RIF 135639	Cassidy, Karen Jean	Premium Fraud	150 day(s) jail 36 month(s) probation		$255
RIF 136369	Cassidy, Phillip Timothy	Premium Fraud	108 month(s) prison	$9,994,883	
RIM 533751	Cho, Meiko Kandra	Uninsured Employer	36 month(s) probation	$125	$520
RIM 517969	Espleta, Joseph Granados	Claimant Fraud	36 month(s) probation	$125	$1,055
RIM 533677	Gallardo, Ruben	Uninsured Employer	36 month(s) probation	$125	$555
RIM 535176	Garcia , Maria Theresa	Uninsured Employer	36 month(s) probation	$125	$1,055
RIM 473789	Garcia, Alonso	Uninsured Employer	24 month(s) probation		$555
RIM 517857	Godoy, Gabriela	Uninsured Employer	36 month(s) probation	$125	$555
RIM 517860	Guadron, Samuel Arnulfo	Uninsured Employer	36 month(s) probation	$125	$520
RIM 533717	Haddad, Ghazi Helal	Uninsured Employer	36 month(s) probation	$125	$1,050
SWF 025352	Hamilton , Paul	Claimant Fraud	60 day(s) jail 36 month(s) probation	$493,836	$220
SWF 025352	Hamilton, Susanna	Claimant Fraud	36 month(s) probation		$255
RIM 535139	Hawara, Munir	Uninsured Employer	36 month(s) probation	$125	$1,085
RIM 517856	Izquierdo, Paz Marlen	Uninsured Employer	36 month(s) probation	$125	$620
RIM 512029	Kaddour, Fawaz Abdul Hassib	Uninsured Employer	36 month(s) probation	$125	$520
RIF 143712	Kennison, Joseph Laban	Uninsured Employer	180 day(s) jail 36 month(s) probation	$14,262	$255
RIF 143712	Kennison, Kimberly Ray	Claimant Fraud	180 day(s) jail 36 month(s) probation		$255
RIM 518825	Khas, Maher Salih	Uninsured Employer	36 month(s) probation		$620

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Riverside					
RIM 533683	Lara, Ricardo Fajardo	Uninsured Employer	36 month(s) probation	$125	$520
RIF 143766	Loucks, Dawn	Premium Fraud	60 day(s) jail 36 month(s) probation		$150
RIM 515822	Morante, Henrry Roy	Uninsured Employer	36 month(s) probation	$125	$665
RIM 523737	Nolte, Michael Lon	Claimant Fraud	30 day(s) jail 36 month(s) probation		$130
RIM 531130	Ordorica, Ismael Jesus	Uninsured Employer	36 month(s) probation	$125	$1,055
RIF 145418	Pena, Honorio	Claimant Fraud	24 month(s) prison		
SWM 067277	Pena, Omar	Uninsured Employer	12 month(s) probation		$965
RIF 135369	Pendergrass, Carter	Premium Fraud	24 day(s) jail		$55
RIF 135369	Pendergrass, Joshua Lee	Premium Fraud	150 day(s) jail 36 month(s) probation		$255
SWM 078020	Remar, Charles Edward	Uninsured Employer	36 month(s) probation	$125	$555
RIF 147868	Sanchez , Marcelo Gusman	Premium Fraud	90 day(s) jail 36 month(s) probation	$449,642	$255
RIM 529848	Sanchez, Martha Eduvijes	Uninsured Employer	36 month(s) probation	$125	$1,085
RIM 533721	Sek, Sophal	Uninsured Employer	36 month(s) probation	$125	$520
RIF 143667	Sepeda, Guadalupe	Premium Fraud	3 day(s) jail 60 month(s) probation	$597,816	$460
RIF 143872	Servin, Rolando Chavez	Claimant Fraud	120 day(s) jail 36 month(s) probation	$28,812	$255
RIF 139803	Shade, Chris Lawrence	Claimant Fraud	36 month(s) probation	$5,000	$135
RIM 517866	Shkoukani, Kahled Nayef	Uninsured Employer	36 month(s) probation	$125	$520
RIF 148006	Soria , Enrique	Premium Fraud	363 day(s) jail 36 month(s) probation		$275
RIM 517900	Tran, Steve Tung	Uninsured Employer	36 month(s) probation	$125	$520
RIF 147868	Valdez, Juana	Premium Fraud	30 day(s) jail 36 month(s) probation		$345
RIM 533749	Vidal , Romeo Mendoza	Uninsured Employer	36 month(s) probation	$125	$555
RIM 517884	Wong, Maria Hernandez	Uninsured Employer	36 month(s) probation	$125	$555
Sacramento					
06F04655	Andrade, Daniel Pete	Claimant Fraud	365 day(s) jail 72 month(s) probation	$243,463	$400
08F00707	Barboza, Armondo Juan	Premium Fraud	90 day(s) jail 36 month(s) probation	$1,299	$400
09F01209	Cox, Samuel Steven	Claimant Fraud	270 day(s) jail 60 month(s) probation	$72,522	$1,200

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Sacramento					
07F02050	Gill, Steven Daniel	Claimant Fraud	180 day(s) jail 60 month(s) probation		$200
07F04337	Hamblin, Richard Dennis	Claimant Fraud	30 day(s) jail 24 month(s) probation Infrml Prob	$7,500	$200
08M11479	Hustrulid, William Steed / Perfect-it Industrial Body & Paint	Claimant Fraud	36 month(s) probation Infrml		$515
09F01596	Lynch, Cameron	Claimant Fraud	120 day(s) jail 36 month(s) probation	$4,376	$600
06F06752	Slaughter, Jeri Paul	Claimant Fraud	365 day(s) jail 60 month(s) probation	$58,880	$200
06F00326	Sorensen, Wayne	Claimant Fraud	30 day(s) jail 60 month(s) probation	$54,771	$200
08F02220	Whiteley, Shane Donald	Premium Fraud	90 day(s) jail 36 month(s) probation Infrml Prob	$7,839	$100
San Bernardino					
MVI801808	Alvarez, Gustavo / Alvarez Tire Shop	Uninsured Employer	36 month(s) probation		$700
FSB800902	Barsz, Ronald	Claimant Fraud	36 month(s) probation	$12,000	$110
MSB808515	Coronel, Gabriel / Coronel Tires	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$1,000
MSB806620	Desalas, Claudia Guzman / Josie's Bakery	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$2,110
MWV807393	Deza, Aida Lucia / Deza Insurance	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$2,100
FWV039955	Digiorgio, Laura	Claimant Fraud	120 day(s) jail 60 month(s) probation	$33,987	$200
MVI804831	Escandor, Richard Corrales / Richard's Coffee & Deli	Uninsured Employer	24 month(s) probation		$1,110
FSB800666	Ewelan, Carla	Claimant Fraud	90 day(s) jail 36 month(s) probation	$27,261	$200
FSB038721	Futter, Michael	Premium Fraud	24 month(s) prison	$178,942	
MBV800105	Gibbons, John / Timberlline Spa	Uninsured Employer	24 month(s) probation 250 hour(s) community service		$2,610
FSB058774	Gibson, Jeanae	Claimant Fraud	80 hour(s) community service	$15,000	$110
FSB057972	Godinez, Vinicio	Claimant Fraud	86 day(s) jail 36 month(s) probation	$27,466	$200

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Bernardino					
MVI900674	Gonzalez, Gustavo Alvarez / Alvarez Tire Shop	Uninsured Employer	60 day(s) jail 36 month(s) probation		$10,110
MVI802507	Graetz, Rebecca / Desert Wholesale	Uninsured Employer	12 month(s) probation 100 hour(s) community service		$2,110
FSB702543	Guillen, Andrew	Claimant Fraud	90 day(s) jail 36 month(s) probation	$40,089	$200
MCH900525	Guillen, Jesus / Certified Transmission	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$2,000
MVA801267	Hong, Thomas Han / Thomas Toys And Electronics	Uninsured Employer	24 month(s) probation		$3,000
MWV805263	Kaing, Chindra / Tasty Donuts	Uninsured Employer	24 month(s) probation		$5,110
MSB900548	Keo, James / Chenla Auto Repair	Uninsured Employer			$1,110
MWV901620	Lao, Maney / dba Mountain Liquor & Market	Uninsured Employer	24 month(s) probation		$1,110
MBV800106	Lecroy, Barbara Ann / Log Cabin Hotel	Uninsured Employer	24 month(s) probation		$3,800
MWV900880	Loepp, Aaron Walter / Terry's Automotive	Uninsured Employer	36 month(s) probation		$2,160
FSB801724	Lucero, Abdon	Other	36 month(s) probation		$1,045
FSB054434	Luke, Linda	Claimant Fraud	24 month(s) probation	$15,000	$150
MVI803819	Massey, Kum / Hesperia Florist	Uninsured Employer	24 month(s) probation		$2,610
MSB900549	Meza, Antonio / dba Tonys Auto Repair & Smog Service	Uninsured Employer	36 month(s) probation		$2,110
MWV805890	Mora, Jesus Flores / Movilnet Wireless Store	Uninsured Employer	24 month(s) probation		$5,130
MWV901621	Park, Tae / Waba Grill	Uninsured Employer	24 month(s) probation		$2,110
FSB702337	Peace, Sheri Lee	Claimant Fraud	90 day(s) jail 36 month(s) probation	$22,448	$200
MSB900550	Rached, Sr., Marco Antonio / Marco Tires	Uninsured Employer	24 month(s) probation		$2,110

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Bernardino					
FVI801043	Rossman, Robert	Claimant Fraud	90 day(s) jail 60 month(s) probation	$20,696	$200
MBV800104	Smith, Eneliko / The Block Hotel	Uninsured Employer	24 month(s) probation		$5,000
MVI039110	Terrell, James / Law Offices Of James Terrell	Uninsured Employer			$9,998
MSB708885	Tran, Lani / Yen Bistro	Uninsured Employer			$5,110
FSB059975	Wagoner, Gary	Single Entity Provider Fraud	1 day(s) jail 36 month(s) probation	$25,000	$110
FSB050003	Waller, Robert	Other	36 month(s) prison		
MVI803296	Waneis, Mtanous / Live Oak Liquor	Uninsured Employer			$10,000
MSB902723	Yi, Bo Kyu / Rainbow Painting	Uninsured Employer	24 month(s) probation		$2,110
San Diego					
M041899	Aguinaldo, Elsie	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
M041898	Alcala, Guillermo	Uninsured Employer			$207
M058691	Amaro, Manuel Silva	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$120
M066231	American Developer, Inc	Uninsured Employer	36 month(s) probation	$2,500	$10,120
M045097	Anderson, Lee M.	Uninsured Employer	1 day(s) jail 36 month(s) probation		$120
M071406	Aon, Lucy A.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
ACL713	Arteaga, Alberto R.	Premium Fraud	109 day(s) jail 36 month(s) probation	$232,152	$954
ACI325	Batchelor, Louise May	Insider Fraud	120 day(s) jail 36 month(s) probation		
ACE782	Berry, Deborah Jean	Uninsured Employer	1 day(s) jail 36 month(s) probation 75 hour(s) community service	$10,000	$979
M044541	Bodie, Brett Randall	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,750	$120
ABV536	Brown, Thomas Edward	Claimant Fraud	1 day(s) jail 36 month(s) probation		$340
M031109	Carrillo, Victor R.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Diego					
M039559	Castillo, Alba	Uninsured Employer	36 month(s) probation	$100	$211
ACK929	Castillo, Miguel A.	Claimant Fraud	1 day(s) jail 36 month(s) probation	$300	
M058693	Castro, Cristobal	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M031107	Choufa, Driss	Uninsured Employer	36 month(s) probation	$4,000	
M031107	Choufa, Holdings, Inc	Uninsured Employer	36 month(s) probation	$4,000	$120
M044544	Cms Unitary Inc	Uninsured Employer	36 month(s) probation	$6,000	$120
M071407	Colon, Artemio D.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$750	$120
ACG191	Cruz, Carlos	Claimant Fraud	120 day(s) jail 36 month(s) probation	$200	$680
M065262	Deleon, Ismael	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M067962	Diaz, Felipe	Uninsured Employer			$207
ACL491	Doke, Charles E.	Claimant Fraud	365 day(s) jail 36 month(s) probation 100 hour(s) community service	$11,609	$800
M041900	Duque, Claudia Victoria	Uninsured Employer			$156
M070283	Engelsman, Christopher	Uninsured Employer	1 day(s) jail 36 month(s) probation	$750	$120
M065263	Felix, Angel A.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
M067959	Felix, Gilbert R.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$120
M041900	Fornari, John C.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$3,000	$120
ACG138	Galindo, Santos	Claimant Fraud	180 day(s) jail 36 month(s) probation	$21,319	$680
ACG220	Gallego, Veronica	Claimant Fraud	1 day(s) jail 36 month(s) probation 180 hour(s) community service	$18,000	$1,467
ABT129	Gardality, Mandana B	Uninsured Employer	36 month(s) probation	$100	
ABT129	Gardality, Steve I	Uninsured Employer	7 day(s) jail 60 month(s) probation	$1,304	
M041903	Gonzalez, Daniel M.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
M045094	Gonzalez, Francisco Diaz	Uninsured Employer	1 day(s) jail 36 month(s) probation	$10,000	$120
ABV650	Groves, Larry Owen	Claimant Fraud	1 day(s) jail 36 month(s) probation	$10,000	

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Diego					
ACE938	Henderson, Andrew C	Claimant Fraud	1 day(s) jail 60 month(s) probation 100 hour(s) community service	$64,845	$920
ACG129	Johnson, Gordon Curtis	Claimant Fraud	180 day(s) jail 36 month(s) probation 80 hour(s) community service	$4,371	
M042755	Khan, Shagufta S.	Uninsured Employer	36 month(s) probation		$172
M041898	Lilly Yo Corporation	Uninsured Employer	36 month(s) probation		$120
M073329	Linvill, John H.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M039559	Lopez, Fortino Higuera	Uninsured Employer	36 month(s) probation	$100	$211
M041896	M.J. Thibault, M. D., Inc	Uninsured Employer	36 month(s) probation	$4,000	$10,120
ACG245	Machesky, Michelle L	Claimant Fraud	1 day(s) jail 60 month(s) probation 400 hour(s) community service	$400	$800
ACL658	Maheshwari, Devda	Multiple Entities Provider Fraud	180 day(s) jail 36 month(s) probation 320 hour(s) community service	$30,400	
M067958	Maldonado, Alfredo	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$120
M065259	Maldonado, Doming	Uninsured Employer	1 day(s) jail 36 month(s) probation	$5,500	$50
ACE771	Malkvist, Robert	Premium Fraud	3 day(s) jail 60 month(s) probation	$621,591	
ACC672	Mcdonald, Michael Bruce	Premium Fraud	1 day(s) jail 120 hour(s) community service	$366,960	$1,159
M044547	Melendez, Martha	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
M056655	Millan, Enrique Chacon	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,250	$120
M056655	Millan, Rafael Anthony	Uninsured Employer	36 month(s) probation	$1,250	$120
ACG175	Moreno, Luis Atrisco	Claimant Fraud	92 day(s) jail 36 month(s) probation		$300
M071409	Nikitchenko, Irina	Uninsured Employer	36 month(s) probation	$2,000	$120
M044544	Nute, James Clough	Uninsured Employer	36 month(s) probation		$100
M065258	Obregon, Ruben	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
MO66232	Ocampo, Jose	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M038056	Paz, Alejandro	Uninsured Employer	36 month(s) probation	$500	$172

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Diego					
M987444	Pearson, David Ezekiel	Uninsured Employer	1 day(s) jail 36 month(s) probation	$750	$120
ABY257	Perez, Leticia	Claimant Fraud	30 day(s) jail 36 month(s) probation 20 hour(s) community service		$663
ACG214	Pete, Tiffany Lanne	Claimant Fraud	36 month(s) probation	$200	
M065256	Phan, Hien Quy	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$70
M038056	Poungded, Sandra C.	Uninsured Employer	36 month(s) probation	$1,000	$120
M065264	Ramos, Hector J.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	
ACM210	Rayas, Jesus Palma	Claimant Fraud	104 day(s) jail 36 month(s) probation	$2,809	$800
M071409	Recht, Lena	Uninsured Employer	36 month(s) probation	$2,000	$120
M042755	Renew Hair & Medical Corp	Uninsured Employer	36 month(s) probation	$4,000	$120
M058692	Ritter, Edward Phillip	Uninsured Employer	36 month(s) probation	$500	$120
M067956	Rodriguez, Leopoldo	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$120
M056010	Ruvalcaba, Martin	Uninsured Employer	36 month(s) probation	$1,000	$120
M040574	Scott, Brett Darren	Uninsured Employer	1 day(s) jail 36 month(s) probation	$4,000	$120
M058690	Sena, Anthony Dino	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
ACC338	Silva, Alejandro	Uninsured Employer	181 day(s) jail 36 month(s) probation	$2,500	$140
M073680	Snyder, Edward	Uninsured Employer	36 month(s) probation		$120
M041896	Thibault, Marie Josee	Uninsured Employer	36 month(s) probation	$4,000	$120
M044545	Topete, Santos	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
ACF890	Travis, Bryon Cordell	Claimant Fraud	1 day(s) jail 36 month(s) probation 80 hour(s) community service	$100	$340
M056008	Valencia, Monica	Uninsured Employer	36 month(s) probation	$1,000	$120
M045095	Van Haeren, Vincent Hugo	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
M058840	Vargas, Wilma V.	Uninsured Employer	1 day(s) jail 36 month(s) probation		$120
M067962	Vartelas, Takis P.	Uninsured Employer	36 month(s) probation	$1,500	$120
ACJ921	Webster, Darien C.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$100	$500

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Diego					
M053607	Whitfield, Brian R.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M053607	Whitfield, Sara Elizabeth	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M013658	Winn, Carol June	Uninsured Employer		$20,000	$156
M073682	Yousif, Othman A.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
M056009	Zaia, Wissam George	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
M067964	Zhidkov, Igor T.	Premium Fraud	1 day(s) jail 36 month(s) probation	$500	$120
M066231	Zora, Fakhry Hermiz	Uninsured Employer			$156
San Francisco					
2379581	Gilton, Barry	Claimant Fraud	1 day(s) jail 12 month(s) probation	$4,000	$120
2292719	Mario, Bobbie	Claimant Fraud	1 day(s) jail 48 month(s) probation	$40,352	$200
2400271	Mccarthy, Philip	Uninsured Employer	25 hour(s) community service		$2,000
2346638	Moore, Sharon	Claimant Fraud	1 day(s) jail 48 month(s) probation	$67,668	$1,200
2382786	Wynne-lura, Michelle	Claimant Fraud	1 day(s) jail 18 month(s) probation 40 hour(s) community service	$1,200	$150
San Joaquin					
SF110307A	Maciejewski, Dave George / Vi-Tech Manufacturing	Claimant Fraud	36 month(s) probation	$1,200	$110
SF102002A	Rigopoulos, Christopher Thomas / San Joaquin County	Claimant Fraud	36 month(s) probation	$10,000	$110
SF109961A	Sabado Jr, Hilario Patricio / Planscape Associates	Uninsured Employer	5 day(s) jail 36 month(s) probation	$2,500	$110
SM267655A	Sandhu, Jagbir Singh / Sunline Logistics	Uninsured Employer	10 day(s) jail 36 month(s) probation		$610
SF103439A	Turner, Nadine Elouise / Memorial Gardens Cemetary	Claimant Fraud	36 month(s) probation	$2,000	$110
SF109893A	Verduzco, Brigido Cano / Mid Valley Plastering	Claimant Fraud	36 month(s) probation	$28,769	$110

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
San Mateo					
SC067518A	Narayan, Alfred / San Mateo County	Claimant Fraud	90 day(s) jail 36 month(s) probation	$97,000	$220
SM354905A	Squires, Steve / 4s Casino Party Suppliers LILC	Uninsured Employer	6 month(s) probation		$566
Santa Barbara					
1307739	Atkeison, Fredric Joseph	Uninsured Employer	36 month(s) probation	$125	$900
1307746	Barajas, Jose De Jesus	Uninsured Employer	36 month(s) probation	$1,000	$125
1285184	Borges, Liana Marie / Borges Quick Stop	Uninsured Employer	36 month(s) probation	$1,000	$245
1259573	Clark, David William / The Cliff Room	Uninsured Employer	36 month(s) probation	$3,000	$145
1307733	Groh, Tommy	Uninsured Employer	36 month(s) probation		$1,145
1307734	Johnson, David Lewis	Uninsured Employer	36 month(s) probation		$2,250
1307749	Lopez, Christobal Hernandez	Uninsured Employer	36 month(s) probation		$2,050
1063004	Real, Jorge Armondo	Other	12 month(s) probation		
1307747	Rodriguez-Guerrero, Jose Manuel	Uninsured Employer	36 month(s) probation	$1,000	$1,125
1283703	Terrones, Jose	Uninsured Employer	36 month(s) probation	$125	$1,000
1307924	Velasco, Richardo / Ricky's House Of Pizza	Uninsured Employer	Civil Restitution		
Santa Clara					
CC892897	August, Tanya	Claimant Fraud	36 month(s) prison 200 hour(s) community service	$20,000	
CC829170	Davis, James Glenn	Other	365 day(s) jail 36 month(s) probation	$1,476	$220
CC897991	Elmore, Steven	Claimant Fraud	1 day(s) jail	$10,000	$110
CC801332	Escobar, Jose Antonio	Claimant Fraud	1 day(s) jail 36 month(s) probation	$30,000	$220
FF826968	Flores, Javier	Uninsured Employer	24 month(s) probation		$110
CC941363	Garcia, Jaime Robert / Empire Collision Center	Uninsured Employer	24 month(s) probation		

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Santa Clara					
CC899678	Ha, Bao / Streetel One	Premium Fraud	364 day(s) jail 36 month(s) probation		$220
CC899678	Huynh, Natalie / Streetel One	Premium Fraud	30 day(s) jail 12 month(s) probation	$10,000	$110
CC941133	Miller, Gary Edwin / Personalized Vans & Trucks	Uninsured Employer	12 month(s) probation		$110
CC941344	Nguyen, Binh Thanh / Quality Autoworks	Uninsured Employer	24 month(s) probation		$110
CC899677	Nguyen, Boa / EZ Wireless	Premium Fraud	270 day(s) jail 36 month(s) probation	$77,500	$220
CC941367	Nguyen, Hai Son / D&H Auto Repair And Towing	Uninsured Employer	24 month(s) probation		$110
CC899677	Nguyen, Trina / EZ Wireless	Premium Fraud	90 day(s) jail 36 month(s) probation		$220
CC941343	Oh, Phillip Hyungsuck / California Glass Tinting	Uninsured Employer	12 month(s) probation		$110
CC941365	Olvera, Juan Jimenez / Artistic Upholstery	Uninsured Employer	24 month(s) probation		$110
CC823853	Ortiz, Carlos	Claimant Fraud	1 day(s) jail 60 month(s) probation	$8,500	$220
CC941342	Park, Jonathan Tae / One Hour Blossom Hill Cleaners	Uninsured Employer	12 hour(s) community service		$110
CC899677	Pham, Jordan / EZ Wireless	Premium Fraud	90 day(s) jail 36 month(s) probation		$220
CC802373	Sagor, Robert / Senior Roofing	Premium Fraud	300 day(s) jail 60 month(s) probation	$48,520	
CC802252	Smith, Alan	Claimant Fraud	pending sentencing		
CC941326	Souther, James / Fratelli Woodwork	Uninsured Employer			$119
CC813999	Stepovich, Caroline	Claimant Fraud	1 day(s) jail 24 month(s) probation	$10,000	$730
CC899678	Tang, Nikki / Streetel One	Premium Fraud	364 day(s) jail 36 month(s) probation	$480,000	$220
CC943297	Tostado, Jose	Uninsured Employer	12 month(s) probation		$110
CC821450	Townsend, Mark	Uninsured Employer	1 month(s) probation		
CC802080	Tran, Qui	Claimant Fraud	3 day(s) jail 60 month(s) probation		

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Santa Clara					
CC941366	Tran, Tony Hoang / Mckee Pure Water	Uninsured Employer	24 month(s) probation		
CC899676	Tran, Xuan / Streetel One	Premium Fraud	30 day(s) jail 12 month(s) probation		$110
CC813729	Warford, Thomas	Claimant Fraud	pending in court		
FF825047	Zermano-topete, Jose	Uninsured Employer	1 day(s) jail 36 month(s) probation		$110
Santa Cruz					
M48826	Calvario, Martin Moya	Uninsured Employer	48 month(s) probation		$10,000
M47970	Ha, Jake Trong	Uninsured Employer	12 month(s) probation		$10,000
M46269	Harting, Sonya Lynn / Spoiled Rotten	Uninsured Employer	36 month(s) probation		$10,000
M46284	Ho, Le Yen / Beautiful Nails	Uninsured Employer	36 month(s) probation		$750
M47975	Ly, Khoa D	Uninsured Employer	12 month(s) probation		$10,000
W15101	Nguyen, Ethan Nhut / Pro Top Nails III	Uninsured Employer	36 month(s) probation		$750
F17439	Orr, Jeffery Roland	Other	36 month(s) probation	$11,000	$350
M48828	Riotutar, Rafael / Burger Alley	Uninsured Employer	36 month(s) probation		$10,000
M46124	Sabala, Jesus Chavez	Other	12 month(s) probation	$500	$220
M48827	Saravia, Rafael Herrera	Uninsured Employer	24 month(s) probation		$10,000
M46286	Thi, Le Ho / Magic Nails	Uninsured Employer	36 month(s) probation		$750
M46715	Thomas, Tony	Other	12 month(s) probation		$275
M47976	Tran, Bich Hong	Uninsured Employer	24 month(s) probation		$1,000
Shasta					
F-08-645	Atkinson, Curtis John / Insurance Company Of The West	Claimant Fraud	120 day(s) jail 36 month(s) probation	$39,263	
09-2623	Beard , David Mark / Beard's Custom Cabinets	Premium Fraud	1 day(s) jail	$110	$360

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Shasta					
09-2623	Beard, Timothy A / Beard's Custom Cabinets	Premium Fraud	1 day(s) jail 36 month(s) probation	$110	$360
07WC719	Higgins, Robert Reid	Uninsured Employer	1 day(s) jail 36 month(s) probation		$630
06IV08288	Jensen, Sandra Marie / AIG	Claimant Fraud	60 day(s) jail 36 month(s) probation	$3,336	
06-04838	Peterson, Scott Milton	Uninsured Employer	3 day(s) jail 36 month(s) probation		
Solano					
FCR235216	Dunham, Carol	Claimant Fraud	Sentencing pending.		
FCR249516	Reyes, Eugenia	Claimant Fraud	60 day(s) jail 36 month(s) probation	$22,614	$400
FCR249824	Whiteley, Shane	Single Entity Provider Fraud	36 month(s) probation	$1,188	$130
Tulare					
07027331	Aubuchon, Michael	Uninsured Employer		$7,600	
09-007021	Barraza, Felipe	Uninsured Employer	36 month(s) probation		$10,160
09-007025	Calderon, Pedro	Uninsured Employer	36 month(s) probation		$10,000
TCM204367	Casey, Fletcher	Uninsured Employer	90 day(s) jail 36 month(s) probation		$1,820
TCM205016	Castaneda, Salvador	Uninsured Employer	36 month(s) probation 40 hour(s) community service		$10,000
DCF164689	Castillo, Jesus	Claimant Fraud	90 day(s) jail 36 month(s) probation	$7,904	$200
VCF180158	Chatten, Missi	Claimant Fraud	365 day(s) jail 36 month(s) probation	$60,759	$1,000
VCF210198	Felemi, Monte Blue	Uninsured Employer	365 day(s) jail 60 month(s) probation	$2,500	$1,050
TCM204367	Joles, Steve	Uninsured Employer	90 day(s) jail 36 month(s) probation		$1,820
TCM203351	Lopez, Ricardo Vicencio	Uninsured Employer	30 day(s) jail 36 month(s) probation		$10,000
TCM200016	Miramontes, Pete	Uninsured Employer	36 month(s) probation 40 hour(s) community service		$1,970
VCF198968	Molina, Carlos	Uninsured Employer	60 day(s) jail 36 month(s) probation	$2,400	$325
0901000119	Navarro, Armando	Uninsured Employer	36 month(s) probation		$1,046
F-00-23828	Perez, Alejandro	Claimant Fraud	45 day(s) jail 12 month(s) probation Restitution order pending		$110

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Tulare					
09-007760	Perez-al, Saul	Uninsured Employer	5 day(s) jail 36 month(s) prison 80 hour(s) community service		$2,000
08012675	Trail, Dewey	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$340
09-007233	Villarreal, Maximino	Uninsured Employer	36 month(s) probation 40 hour(s) community service		$560
Ventura					
2004023261	AFCO Construction	Premium Fraud	36 month(s) probation	$119,171	
2004023261	Afghani, Saeid	Premium Fraud	36 month(s) probation	$119,171	
2004022843	Anderson, Norman	Claimant Fraud	48 month(s) prison	$97,425	$800
2009013942	Arana, Gustavo	Uninsured Employer	24 month(s) probation		$10,000
2008052161	Bill Mayer Saddles, Inc.	Uninsured Employer	24 month(s) probation		$10,000
2008011228	Casillas, Juan	Uninsured Employer	24 month(s) probation		$10,000
2008044898	Dagher, Waleid	Uninsured Employer	24 month(s) probation		$10,000
2006014079	Eiselle, Alexandra	Claimant Fraud	180 day(s) jail 60 month(s) probation	$40,572	
2009001067	Galvez, Jose Luis-garcia	Uninsured Employer	24 month(s) probation		$10,000
2008035337	Goble, Sandra Darlene	Uninsured Employer	24 month(s) probation		$10,000
2008012213	Gomez, Ernest	Uninsured Employer	24 month(s) probation		$10,000
2008038996	Korpas, Tony Gyula	Claimant Fraud	24 month(s) probation		$10,000
2008053598	Lopez, Fidel	Uninsured Employer	24 month(s) probation		$10,000
2009011342	Monreal, Fermin	Uninsured Employer	24 month(s) probation		$10,000
2009003605	Ortega, David	Uninsured Employer	24 month(s) probation		$10,000
2008047111	Ozawa, Dexter	Uninsured Employer	24 month(s) probation		$10,000
2009001551	Perez, Edward Vega	Claimant Fraud	24 month(s) probation		$10,000
2008046273	Porras, Jose	Uninsured Employer	24 month(s) probation		$10,000
2008030143	Portillo, Jesus Manuel	Uninsured Employer	24 month(s) probation		$10,000
2008045015	Predescu, Beatrice	Uninsured Employer	24 month(s) probation		$10,000
2009000765	R&R Mattress Warehouse	Uninsured Employer	24 month(s) probation		$10,000
2009011816	Rojo, Martin Herrera	Uninsured Employer	24 month(s) probation		$10,000
2008044906	Sanchez, Claudia	Uninsured Employer	24 month(s) probation		$10,000
2008008043	Schoonover, Steven	Uninsured Employer	24 month(s) probation		$10,000

6.) Workers' Compensation Fraud Convictions (Fiscal Year 2008-09) (continued)

Case Number	Subject Name	Role	Sentence	Restitution	Criminal Fine
Ventura					
2009003346	Thuan Thuy, Inc.	Uninsured Employer	24 month(s) probation		$10,000
2007011237	Vasquez, Jose	Claimant Fraud	180 day(s) jail 60 month(s) probation	$98,801	$300
Yolo					
08S-PN-003	Avila, Jose Hernandez / Jr's Handyman Service	Uninsured Employer	36 month(s) probation 80 hour(s) community service		$1,130
09SPN027	Azevedo, Timothy / Azevedo Paint & Auto Body Shop	Uninsured Employer			$1,000
02SWC122	Banderas, Sara Fletes	Claimant Fraud		$21,500	
06M04911	Fuller, Kelli / Spa Central	Uninsured Employer		$125	$8,033
03SWC003	Griffin, Guy Peppy	Claimant Fraud	90 day(s) jail	$20,000	$2,320
07SWC032	Kiesz, Kevin Dewalt	Uninsured Employer			$634
08SWC015	Mcglothlin, Michael / Golden Days Adhcc	Uninsured Employer	36 month(s) probation		$2,040
08SWC035	Perry, Ronald	Uninsured Employer			$656
09SPN008	Seidel Iii, Billy	Claimant Fraud	80 hour(s) community service 3 Years Summary Court Probation		$1,160

7-a.) Arrest-Prosecution Summary (Part One)

COUNTY	ARRESTS		PROSECUTIONS			CONVICTIONS	
	Felony	Misdemeanor	Cases	Suspects	Total Chargeable	Felony	Misdemeanor
Alameda	14	18	97	105	$1,765,597	10	27
Amador	2	0	8	9	$0	1	5
Butte	0	9	14	14	$0	0	6
Contra Costa	2	5	40	41	$434,118	1	13
El Dorado	2	2	37	38	$0	4	19
Fresno	7	10	49	51	$2,725,808	10	16
Humboldt	0	1	2	2	$0	0	0
Imperial	2	0	4	4	$58,714	1	0
Kern	3	43	47	50	$2,516,000	3	21
Kings	1	0	1	1	$0	0	0
Los Angeles	51	11	108	126	$46,881,100	44	24
Madera	0	0	3	3	$188,000	0	0
Marin	2	2	5	5	$17,529	0	3
Mendocino	0	0	3	3	$0	0	0
Merced	11	0	5	20	$1,036,741	0	2
Monterey	1	2	10	12	$127,490	1	3
Orange	6	24	79	90	$165,495,509	6	30
Riverside	2	28	37	40	$1,600,000	15	24
Sacramento	10	1	29	31	$3,824,016	7	3
San Bernardino	1	19	63	80	$45,512,800	7	29
San Diego	45	69	198	198	$14,533,129	25	68
San Francisco	2	1	9	10	$1,346,925	2	2
San Joaquin	7	6	20	27	$12,787,300	0	6
San Luis Obispo	0	0	3	3	$0	1	0
San Mateo	1	0	11	12	$369,753	1	1
Santa Barbara	0	3	12	12	$0	0	2
Santa Clara	18	28	67	88	$8,045,902	17	23
Santa Cruz	0	12	21	21	$0	1	12

7-a.) Arrest-Prosecution Summary (Part One) (continued)

COUNTY	ARRESTS		PROSECUTIONS			CONVICTIONS	
	Felony	Misdemeanor	Cases	Suspects	Total Chargeable	Felony	Misdemeanor
Shasta	3	5	11	12	$45,424	1	6
Siskiyou	0	0	5	5	$0	0	0
Solano	1	1	7	7	$360,577	2	1
Sonoma	2	1	8	8	$76,000	1	2
Tehama	0	0	0	0	$0	0	0
Tulare	7	14	25	32	$628,200	3	13
Tuolumne	0	0	0	0	$0	0	0
Ventura	4	31	37	46	$1,421,560	3	23
Yolo	3	4	15	15	$206,512	0	4
TOTAL	**210**	**350**	**1090**	**1221**	**$312,004,704**	**167**	**388**

7-b.) Arrest-Prosecution Summary (Part 2)

COUNTY	PENALTIES		RESTITUTION		SEARCH WARRANTS	
	Ordered	Collected	Ordered	Collected	Search Warrants Issued	Number of Suspects
Alameda	$35,195	$10,500	$376,227	$76,123	0	0
Amador	$8,665	$10,415	$1,500	$494	1	2
Butte	$26,136	$0	$20,720	$0	0	0
Contra Costa	$14,845	$9,111	$38,106	$42,400	0	0
El Dorado	$12,880	$13,509	$81,356	$5,200	0	0
Fresno	$3,200	$3,200	$795,392	$121,194	7	7
Humboldt	$320	$0	$0	$0	0	0
Imperial	$0	$0	$6,156	$0	0	0
Kern	$23,634	$5,499	$75,351	$54,258	2	4
Kings	$0	$0	$0	$0	2	4
Los Angeles	$52,995	$6,280	$4,759,432	$546,716	56	15
Madera	$0	$0	$0	$0	0	0
Marin	$0	$0	$2,000	$0	0	0
Mendocino	$0	$0	$0	$0	0	0
Merced	$885	$2,325	$100	$4,560	0	0
Monterey	$30,120	$11,120	$118,659	$50,381	0	0
Orange	$126,005	$21,019	$2,715,919	$115,401	14	14
Riverside	$90,162	$15,143	$10,689,878	$2,232,221	23	17
Sacramento	$4,015	$375	$487,350	$6,389	0	0
San Bernardino	$136,506	$120,185	$425,225	$111,100	6	3
San Diego	$18,907	$0	$1,623,662	$654,521	59	87
San Francisco	$4,670	$3,000	$116,640	$27,400	2	1
San Joaquin	$1,160	$3,548	$44,469	$228,110	1	1
San Luis Obispo	$0	$0	$0	$0	0	0
San Mateo	$786	$2,244	$97,226	$38,000	0	0
Santa Barbara	$145	$145	$3,000	$3,000	0	0
Santa Clara	$2,733	$796	$597,500	$647,671	5	8
Santa Cruz	$110,350	$11,350	$11,000	$11,000	0	0
Shasta	$6,176	$1,190	$45,534	$1,972	0	0
Siskiyou	$0	$0	$0	$0	0	0
Solano	$530	$0	$24,990	$6,265	0	0
Sonoma	$2,467	$2,347	$62,574	$57,379	0	0
Tehama	$0	$0	$0	$0	0	0
Tulare	$30,794	$3,679	$151,513	$21,209	0	0
Tuolumne	$0	$0	$0	$0	0	0

7-b.) Arrest-Prosecution Summary (Part 2) (continued)

COUNTY	PENALTIES		RESTITUTION		SEARCH WARRANTS	
	Ordered	Collected	Ordered	Collected	Search Warrants Issued	Number of Suspects
Ventura	$212,000	$21,647	$355,969	$218,839	0	0
Yolo	$16,317	$11,297	$40,000	$400	0	0
TOTAL	**$972,598**	**$289,924**	**$23,767,448**	**$5,282,203**	**178**	**163**

7-c.) District Attorney's Type of Investigations – Fiscal Year 2008-09

County	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider Fraud	Uninsured Employer	Other	TOTAL
Alameda	60	6	1	5	0	20	5	**97**
Amador	43	11	0	1	0	16	1	**72**
Butte	21	0	0	0	0	23	16	**60**
Contra Costa	28	3	0	2	2	39	1	**75**
El Dorado	5	1	00	0	0	24	4	**34**
Fresno	30	16	0	0	0	25	5	**76**
Humboldt	9	4	0	2	0	2	0	**17**
Imperial	4	0	0	0	0	0	0	**4**
Kern	25	8	10	3	0	10	36	**92**
Kings	20	5	1	0	0	2	1	**29**
Los Angeles	96	21	8	7	2	67	14	**215**
Madera	0	0	0	0	0	7	0	**7**
Marin	31	3	0	13	0	3	0	**50**
Mendocino	0	0	0	0	0	0	0	**0**
Merced	21	0	0	0	0	0	0	**21**
Monterey	5	0	0	0	0	10	26	**47**
Orange	66	25	1	26	4	68	7	**197**
Riverside	39	24	1	4	0	18	0	**86**
Sacramento	53	8	0	1	0	5	2	**69**
San Bernardino	36	11	1	6	0	26	0	**80**
San Diego	280	23	1	6	3	72	3	**388**
San Francisco	15	1	0	0	1	5	0	**22**
San Joaquin	53	3	1	1	1	6	0	**65**
San Luis Obispo	7	0	0	0	0	0	0	**7**
San Mateo	22	3	0	0	0	4	0	**29**
Santa Barbara	9	2	0	2	0	13	1	**27**
Santa Clara	31	16	0	3	0	24	2	**76**
Santa Cruz	2	0	0	0	0	18	0	**20**
Shasta	27	2	0	0	0	10	0	**39**
Siskiyou	5	0	0	0	0	0	0	**5**
Solano	25	3	0	0	0	3	0	**31**
Sonoma	7	0	2	0	0	8	0	**17**
Tehama	0	0	0	0	0	0	0	**0**
Tulare	17	7	0	1	0	13	0	**38**
Tuolumne	4	0	0	0	0	0	0	**4**
Ventura	25	7	0	2	2	211	1	**248**
Yolo	12	0	0	0	0	10	0	**31**
TOTAL	**1,133**	**213**	**27**	**91**	**15**	**771**	**125**	**2,375**

8-a.) Standard and Medium Cases in Court

County	Standard Cases in Court							
	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider fraud	Uninsured Employment	Others	Sub-Total
Alameda	39					35	7	**81**
Amador	2	1				5		**8**
Butte						7		**7**
Contra Costa	3					30		**33**
El Dorado		2				18	12	**32**
Fresno	2							**2**
Humboldt	1					1		**2**
Imperial	2							**2**
Kern				1		8	34	**43**
Kings	1							**1**
Los Angeles	10			1	1	12	1	**25**
Madera						1	1	**2**
Marin						3		**3**
Mendocino	3							**3**
Merced						1		**1**
Monterey	3					1		**4**
Orange	9	1		1		39		**50**
Riverside	4	1				21		**26**
Sacramento	10	1		1		2	2	**16**
San Bernardino	2					36		**38**
San Diego	21	1			1	108	2	**133**
San Francisco	2					2		**4**
San Joaquin	4					3		**7**
San Luis Obispo								**0**
San Mateo	1					5		**6**
Santa Barbara						11	1	**12**
Santa Clara	15	1				28	2	**46**
Santa Cruz						21		**21**
Shasta	3	1				7		**11**
Siskiyou	1							**1**
Solano	1			1				**2**
Sonoma	3					2	1	**6**
Tehama								**0**
Tulare	7					9		**16**
Tuolumne								**0**
Ventura	2					26		**28**
Yolo						9		**9**
TOTAL	**151**	**9**	**0**	**5**	**2**	**451**	**63**	**681**

8-a.) Standard and Medium Cases in Court (continued)

County	Medium Cases in Court							
	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider fraud	Uninsured Employment	Others	Sub-Total
Alameda	4							**4**
Amador								**0**
Butte	3					2		**5**
Contra Costa	1					2		**3**
El Dorado	3					2		**5**
Fresno	14					16		**30**
Humboldt								**0**
Imperial	2							**2**
Kern		1						**1**
Kings								**0**
Los Angeles	45	1	1				1	**48**
Madera								**0**
Marin				1				**1**
Mendocino								**0**
Merced	1							**1**
Monterey						3		**3**
Orange	13	2				1		**16**
Riverside	2	4						**6**
Sacramento	9	1						**10**
San Bernardino	8							**8**
San Diego	18	1			1	2		**22**
San Francisco	2							**2**
San Joaquin	8							**8**
San Luis Obispo	2							**2**
San Mateo	1							**1**
Santa Barbara								**0**
Santa Clara	8	1						**9**
Santa Cruz								**0**
Shasta								**0**
Siskiyou	4							**4**
Solano	2							**2**
Sonoma	1							**1**
Tehama								**0**
Tulare	2					5	1	**8**
Tuolumne								**0**
Ventura	1							**1**
Yolo	1							**1**
TOTAL	**155**	**11**	**1**	**1**	**1**	**33**	**2**	**204**

8-b.) Complex and Very Complex Cases in Court

County	Complex Cases in Court							
	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider fraud	Uninsured Employment	Others	Sub-Total
Alameda	2	3					4	**9**
Amador								**0**
Butte	1							**1**
Contra Costa	2	1						**3**
El Dorado								**0**
Fresno	7	3		1		4	1	**16**
Humboldt								**0**
Imperial								**0**
Kern	1							**1**
Kings								**0**
Los Angeles	19	2			1			**22**
Madera	1							**1**
Marin								**0**
Mendocino								**0**
Merced		1	2					**3**
Monterey						1		**1**
Orange	1	1	1	1	1			**5**
Riverside	1					1		**2**
Sacramento	1	1						**2**
San Bernardino	8	1		1				**10**
San Diego	8	6	2			3		**19**
San Francisco	1	1						**2**
San Joaquin	2			1				**3**
San Luis Obispo	1							**1**
San Mateo	2							**2**
Santa Barbara								**0**
Santa Clara		3					1	**4**
Santa Cruz								**0**
Shasta								**0**
Siskiyou								**0**
Solano	3							**3**
Sonoma		1						**1**
Tehama								**0**
Tulare		1						**1**
Tuolumne								**0**
Ventura	5				1			**6**
Yolo	5							**5**
TOTAL	**71**	**25**	**5**	**4**	**3**	**9**	**6**	**123**

8-b.) Complex and Very Complex Cases in Court (continued)

County	Very Complex Cases in Court							
	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider fraud	Uninsured Employment	Others	Sub-Total
Alameda							3	**3**
Amador								**0**
Butte		1						**1**
Contra Costa	1							**1**
El Dorado								**0**
Fresno	1							**1**
Humboldt								**0**
Imperial								**0**
Kern			1				1	**2**
Kings								**0**
Los Angeles	2	9		1	1			**13**
Madera								**0**
Marin				1				**1**
Mendocino								**0**
Merced								**0**
Monterey			1			1		**2**
Orange		6	1		1			**8**
Riverside		3						**3**
Sacramento		1						**1**
San Bernardino	1	6						**7**
San Diego	2	17				5		**24**
San Francisco					1			**1**
San Joaquin		1	1					**2**
San Luis Obispo								**0**
San Mateo	1	1						**2**
Santa Barbara								**0**
Santa Clara		4					4	**8**
Santa Cruz								**0**
Shasta								**0**
Siskiyou								**0**
Solano								**0**
Sonoma								**0**
Tehama								**0**
Tulare								**0**
Tuolumne								**0**
Ventura	1	1						**2**
Yolo								**0**
TOTAL	**9**	**50**	**4**	**2**	**3**	**6**	**8**	**82**

8-c.) Cases in Court — Prosecuting Caseload

County	Total Cases	Total Defendants	Total Chargeable Fraud
Alameda	97	105	$1,765,597
Amador	8	9	$0
Butte	14	14	$0
Contra Costa	40	41	$434,118
El Dorado	37	38	$0
Fresno	49	51	$2,725,808
Humboldt	2	2	$0
Imperial	4	4	$58,714
Kern	47	50	$2,516,000
Kings	1	1	$0
Los Angeles	108	126	$46,881,100
Madera	3	3	$188,000
Marin	5	5	$17,529
Mendocino	3	3	$0
Merced	5	20	$1,036,741
Monterey	10	12	$127,490
Orange	79	90	$165,495,509
Riverside	37	40	$1,600,000
Sacramento	29	31	$3,824,016
San Bernardino	63	80	$45,512,800
San Diego	198	198	$14,533,129
San Francisco	9	10	$1,346,925
San Joaquin	20	27	$12,787,300
San Luis Obispo	3	3	$0
San Mateo	11	12	$369,753
Santa Barbara	12	12	$0
Santa Clara	67	88	$8,045,902
Santa Cruz	21	21	$0
Shasta	11	12	$45,424
Siskiyou	5	5	$0
Solano	7	7	$360,577
Sonoma	8	8	$76,000
Tehama	0	0	
Tulare	25	32	$628,200
Tuolumne	0	0	$0
Ventura	37	46	$1,421,560
Yolo	15	15	$206,512
TOTAL	**1090**	**1221**	**$312,004,704**

9-a.) Case Referrals—Part One

County	Fraud Division				Private Carrier				Local Law Enforcement				Third Party Administrator			
	P	A	R	S-T	P	A	R	S-T	P	A	R	S-T	P	A	R	S-T
Alameda	5	1		**6**	13	1	1	**15**	8	11		**19**	7	1	5	**13**
Amador	4			**4**				**0**	2	4	1	**7**				**0**
Butte	3	3	1	**7**				**0**	2	2		**4**	4	4		**8**
Contra Costa	2	1		**3**		1	2	**3**		13		**13**			1	**1**
El Dorado	2			**2**				**0**				**0**				**0**
Fresno				**0**	1	1		**2**				**0**	1	1	1	**3**
Humboldt	2	2	3	**7**	2	1	2							1		
Imperial		1		**1**				**0**				**0**		1	1	**2**
Kern		49	1	**50**	2	4	20	**26**	1	1	1	**3**	1	1	5	**7**
Kings				**0**			1	**1**				**0**		1		**1**
Los Angeles	4	5		**9**	64	47	44	**155**		3		**3**	19	17	30	**66**
Madera		1	1	**2**				**0**				**0**				**0**
Marin		11	2	**13**		9	3	**12**				**0**				**0**
Mendocino	14			**14**				**0**				**0**				**0**
Merced				**0**		2	8	**10**		1		**1**	1	4	7	**12**
Monterey		1		**1**	1	1		**2**				**0**				**0**
Orange	1	1	9	**11**	31	21	19	**71**				**0**		1	4	**5**
Riverside		2		**2**	1	10	1	**12**	1	27		**28**	1	12	1	**14**
Sacramento	2	3		**5**	1	6	5	**12**		2	1	**3**		7	9	**16**
San Bernardino		2		**2**				**0**	1			**1**	5			**5**
San Diego	2	1	2	**5**	20	4	1	**25**	1	1		**2**			2	**2**
San Francisco	3	1	4	**8**	4		3	**7**				**0**	2			**2**
San Joaquin	0	5	0	**5**	7	7	3	**17**	1	1	0	**2**	3	3	1	**7**
San Luis Obispo		1		**1**		1		**1**		1		**1**				**0**
San Mateo		7		**7**		3	1	**4**				**0**		1	1	**2**
Santa Barbara		1		**1**		2		**2**				**0**			1	**1**
Santa Clara				**0**	35	24	22	**81**				**0**		4		**4**
Santa Cruz	20			**20**		3		**3**		18		**18**				**0**
Shasta		2		**2**		13		**13**		1		**1**		1		**1**
Siskiyou	1			**1**	3			**3**				**0**				**0**
Solano		6		**6**	6	8	11	**25**		5	1	**6**	5		4	**9**
Sonoma	2	2	3	**7**				**0**				**0**				**0**
Tehama				**0**				**0**				**0**				**0**
Tulare	4			**4**	8			**8**	5	8		**13**	4	1	1	**6**
Tuolumne	3			**3**				**0**				**0**				**0**
Ventura	2	7		**9**	5	6	3	**14**	1	9		**10**		1	1	**2**
Yolo	1	3		**4**		1		**1**		7	2	**9**	3	1	2	**6**
TOTAL	**77**	**119**	**26**	**222**	**204**	**176**	**150**	**525**	**23**	**115**	**6**	**144**	**56**	**63**	**77**	**195**

P: Pending **A**: Accepted **R**: Rejected **S-T**: Sub-total

9-b.) Case Referrals—Part Two

County	Department of Industrial Relations				Others				TOTAL			
	P	A	R	S-T	P	A	R	S-T	P	A	R	S-T
Alameda	1			**1**	7	16	1	**24**	41	30	7	**78**
Amador				**0**	1			**1**	7	4	1	**12**
Butte		11	1	**12**		38		**38**	9	58	2	**69**
Contra Costa				**0**			1	**1**	2	15	4	**21**
El Dorado				**0**	16	4	4	**24**	18	4	4	**26**
Fresno				**0**				**0**	2	2	1	**5**
Humboldt	1	1		**2**	1	1		**2**	6	6	5	**17**
Imperial				**0**				**0**	0	2	1	**3**
Kern				**0**	2	1		**3**	6	56	27	**89**
Kings				**0**				**0**	0	1	1	**2**
Los Angeles				**0**	9	70	4	**83**	96	142	78	**316**
Madera				**0**				**0**	0	1	1	**2**
Marin				**0**				**0**	0	20	5	**25**
Mendocino				**0**				**0**	14	0	0	**14**
Merced				**0**		1		**1**	1	8	15	**24**
Monterey				**0**				**0**	1	2	0	**3**
Orange				**0**		6		**6**	32	29	32	**93**
Riverside				**0**	1			**1**	4	51	2	**57**
Sacramento				**0**		3	7	**10**	3	21	22	**46**
San Bernardino				**0**	2			**2**	8	2	0	**10**
San Diego	30	31		**61**	2			**2**	55	37	5	**97**
San Francisco	1	2	1	**4**				**0**	10	3	8	**21**
San Joaquin	0	1	0	**1**	0	1	2	**3**	11	18	6	**35**
San Luis Obispo				**0**				**0**	0	3	0	**3**
San Mateo				**0**		4		**4**	0	15	2	**17**
Santa Barbara				**0**				**0**	0	3	1	**4**
Santa Clara		8		**8**		1		**1**	35	37	22	**94**
Santa Cruz				**0**				**0**	20	21	0	**41**
Shasta				**0**		8		**8**	0	25	0	**25**
Siskiyou				**0**			1	**1**	4	0	1	**5**
Solano				**0**				**0**	11	19	16	**46**
Sonoma				**0**				**0**	2	2	3	**7**
Tehama				**0**				**0**	0	0	0	**0**
Tulare				**0**	2			**2**	23	9	1	**33**
Tuolumne				**0**				**0**	3	0	0	**3**
Ventura				**0**	3	5	6	**14**	11	28	10	**49**
Yolo				**0**		1	2	**3**	4	13	6	**23**
TOTAL	**33**	**54**	**2**	**89**	**46**	**160**	**28**	**234**	**439**	**687**	**289**	**1,415**

P: Pending **A**: Accepted **R**: Rejected **S-T**: Sub-total

10.) Press Clippings for Fiscal Year 2008 – 09

PRESS CLIPPINGS

Downey Insurance Broker Booked for Grand Theft ..... August 14, 2008
5 Nail Salons Cited for Lack of Insurance ..... August 14, 2008
Big or Small, Determined Department of Insurance Investigators Don't
Discriminate Against Scam Artists ..... August 20, 2008
Possible Workers' Comp Fraud Results in Federal Indictment ..... October 3, 2008
Sac City Ex-Employee Sentenced in Workers' Comp Case ..... October 12, 2008
San Carlos Couple Arrested in Alleged Insurance Scam ..... October 17, 2008
Newport Insurance Agent gets 10 Years for $2.5 Million Fraud ..... November 3, 2008
2 SoCal Men Charged in Workers' Comp. Case ..... December 1, 2008
DA's Fraud Unit Arrests Ione Man ..... December 11, 2008
Unlicensed Contractors Targeted in Sylmar Sting Operation ..... December 12, 2008
12 Charged in Orange County District Attorney's Fraud Sting ..... February 4, 2009
Ex-Palo Alto Firefighter Could Face Prison for Bilking City ..... April 6, 2009
Unlicensed Contractors Plead Guilty to Felony Charges ..... April 14, 2009
Janitors Busted on $6.3M Workers' Comp Scheme ..... April 15, 2009
L.A. County Reserve Deputy is Accused of Fraud at His Security Firm ..... April 16, 2009
CA Commissioner Announces Prison Librarian Arraigned for WC Fraud ..... April 24, 2009
Roofing Business Alleged in State's Largest Workers' Comp Fraud Scam ..... May 1, 2009
4 Held in Alleged $1.5 Million Scam ..... May 6, 2009
4 Charged with 144 Felonies in Multimillion-Dollar Fraud Case ..... May 11, 2009
Bakersfield Woman Charged with Insurance Fraud ..... May 15, 2009
Owner of Salinas Portable Toilet Company Failed to Insure, Report Workers ..... May 21, 2009
Rialto Woman Jailed After Pleading Guilty in Workers' Comp Case ..... May 26, 2009

2009 ANNUAL REPORT

LEGAL BRANCH

Auto Enforcement Bureau

The Auto Enforcement Bureau (AEB) litigates enforcement actions against insurance companies and Broker-Agents (producers). As an Enforcement bureau, AEB protects policyholders, prospective policyholders, consumers, 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 Vehicle Service Contracts, including the review of contracts and forms, and evaluation of Vehicle Service Contract Provider license applications, and related license disciplinary matters. In addition to automobile issues, AEB also handles all aspects of litigation and enforcement previously known as “compliance” cases. AEB attorneys prepare and file pleadings and represent the Commissioner in administrative court in disciplinary actions against both licensed and unlicensed insurers and producers, including the revocation or denial of licenses and imposing fines for unfair claims practices by insurers.

Beyond its core function of an enforcement litigation bureau, AEB also provides legal opinions to the Commissioner and to the various divisions of the Department; provides support for investigations of producers and examinations of insurers; promulgates regulations; and represents the Department in employee adverse actions.

Auto Enforcement Bureau Statistics: 2009

In 2009 the Auto Enforcement Bureau conducted sixteen (16) administrative hearings to conclusion.

Monetary penalties and costs obtained through negotiated settlements and/or hearings totaled approximately $845,393.00.

267 new matters were opened in 2009
204 matters were closed in 2009

Matter Type	Matters Opened	Matters Closed
Disciplinary	55	70
Vehicle Service Contract	186	111
Unfair Practices Act	0	4
Legal Opinion	3	6
Legislation(analysis of pending bill)	5	5
Miscellaneous	9	4
Human Resources	2	1
Noncompliance	0	1
Order to Show Cause	6	1
Oversight	1	1
Total:	267	204

Corporate Affairs Bureaus - I and II

Application Type	Beg # Assigned Cases	Assigned	Closed	End # Assigned Cases
Amended Certificate of Authority	4	0	3	1
Approved of Trust	6	5	1	10
C/A Amend-Add Line	20	22	20	22
C/A Amend/Delete Line	0	2	2	0
C/A Amend-Domestic Change 709.	2	3	5	0
C/A Amend-Name	8	26	27	7
C/A Amend-Non-Domestic Redomi	7	18	11	14
Certificate of Authority	13	35	28	20
Certificate of Authority-Status – 70	31	8	16	23
Custodian Qualification	2	5	5	2
Custody Agreement	3	12	5	10
Exemption -Certificate of	5	1	1	5
Failure to Make Required Filing	3	0	3	0
Grants/Annuities - C/A	39	25	16	48
Grants/Annuities-Amended C/A	1	1	1	1
HC Disclaimer of Affiliation .41	10	6	11	5
HC Exempt - Comm Domiciled State	2	1	3	0
HC Exempt - Form A.2f	4	23	24	3
HC Extraordinary Dividend .5g	7	22	28	1
HC Mtg. Serv./Cost Share Agmt.5	160	175	181	154
HC Guarantee .5b5	0	1	1	0
HC Misc.	1	1	2	0
HC Reinsurance .5b3	33	48	43	38
HC Sales Purchases Loans. 5b1	4	13	8	9
Holding Companies Acquisition	6	20	15	11
Letter of Credit	0	3	3	0
Merger	18	34	38	14
Miscellaneous	17	28	26	19
Motor Club License	2	0	2	0
Motor Club Service Contract	4	15	11	8
Name Approval Reservation	18	109	98	29
Organizational Permit	5	0	5	0
Rein/Sale-Purchase/Trans-Ass	23	24	21	26
Reinsurer Accreditation	32	33	37	28
Risk Purchasing Group	15	20	26	9
Risk Purchasing Group Renewal	14	265	279	0
Risk Retention Group	11	6	3	14

Corporate Affairs Bureaus - I and II (continued)

Application Type	Beg # Assigned Cases	Assigned	Closed	End # Assigned Cases
Risk Retention Group Renewal	61	109	91	79
S810	2	0	1	1
Stock Permit	4	6	6	4
Stock Permit-Amend	0	1	1	0
Surplus Line Filing	24	2	24	2
UTC-Amended License	4	6	6	4
UTC-License	2	1	3	0
UTC-Organizational Permit	0	1	1	0
UTC-Permit	0	1	1	0
UTC-Transfer of Shares	2	6	4	4
Viatical Settlement Broker	0	1	1	0
Viatical Settlement Contract License	3	0	2	1
Viatical Settlement Provider	1	2	2	1
WC Deposit Agreement	1	11	12	0
WC Deposit Deficiency	0	96	82	14
Withdrawal	9	9	6	12
Total:	643	1262	1252	653

Enforcement Bureau – Sacramento

New cases received 1497
Closed/disposed.....1485

CONSENT.....591

Cease and Desist.....2

Order for Monetary Penalty and or/Reimbursement.....3

Order of Immediate Suspension.....0

Order Removing Restrictions 63

Miscellaneous Orders.....42

Order of Dismissal/Application Withdrawn 2

Order for Monetary Penalty in Lieu of Suspension.....0

Order of Denial.....200

Order of Denial/Issuance of Restricted License 188

Order of Revocation 46

Order of Revocation/Issuance of Restricted License 32

Order of Dismissal/Surrender of License.....6

Order of Dismissal.....7

DEFAULT 201

Order of Revocation 117

Order of Denial.....84

HEARING.....179

Order of Approval/Issuance.....0

Miscellaneous 0

Order of Denial.....73

Order of Denial/Issuance of Restricted License 34

Order of Revocation 48

Order of Revocation/Issuance of Restricted License 22

Order of Dismissal.....2

INFORMAL ACTION...316

Warning.....9

Voluntary Withdrawal of Application.....1

Voluntary Surrender of License.....2

No Disciplinary Action Warranted/Out of License.....0

No Disciplinary Action Warranted.....72

No AR Action/Referred to Discip 232

Miscellaneous 0

SUMMARY.....491

Order of Summary Denial.....215

Order of Summary Denial/Issuance of Restricted License.....135

Order of Summary Revocation.....28

Order of Summary Revocation/Issuance of Restricted License 13

LEGAL OPINION.....12

Closed cases.....12

Enforcement Bureau – San Francisco

ACTIVITIES (JANUARY 1, 2009 THROUGH DECEMBER 31, 2009)

During the year, 149 cases were received and action was completed on 189.

Order of Revocation 32

Order of Revocation/Issuance of Restricted License 15

Order of Denial 15

Order of Denial/Issuance of Restricted License 14

Order of Immediate Suspension 0

Order of Suspension 3

Order of Monetary Penalty &/or Reimbursement 10

Order of Dismissal 1

Order Removing Restrictions 3

Miscellaneous Orders 84

No Disciplinary Action Warranted 19

Warning 0

Order of Summary Revocation 15

Order to Cease & Desist 15

ENFORCEMENT ACTIONS:

Insurer Matters: (Monetary Penalties)

Anthem Blue Cross Life and Health Insurance Company $1,000,000.00

Conseco Senior Health Insurance Company $500,000.00

Hartford Life and Accident Insurance Company $70,000.00

New York Life Insurance Company $175,000.00

Title Insurance Rebating Violations: (Monetary Penalties)

Equity Title Company $300,000.00

Fidelity National Title Company $345,000.00

Lizett Alcaraz, registered Title Marketing Representative $1,570.00

Commerce Title Company $21,600.00

Nations Title Company of California $4,000.00

Cease and Desist Orders:

Alliance Title Company, Inc.

Bail Yes, Inc., Jose Miguel Mastrapa, Dolores Mastrapa, and Steven Martin Morales

Financial Title Company

First Mercury Insurance Company and CoverX Corporation DBA CoverX Insurance Services

First Mercury Insurance Company, CoverX Corp DBA CoverX Insurance Services, and First Mercury Emerald Insurance Services, Inc.

Lenders Choice Title Company

Fraud Liaison Bureau

The Fraud Liaison Bureau (FLB) provides legal support to the Department's Fraud Division (FD). The FD investigates and submits cases to numerous district attorney offices throughout the state. Funding for the criminal prosecution of these cases is provided through various state-wide grant programs.

Legal Support to Fraud Division Executive and Regional Offices

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 various grant programs, as well as the promulgation of regulations, drafting of proposed legislation, and related legal matters.

Fraud Division Programs

1. **Workers' Compensation Insurance Fraud Program -** FD receives mandated funding set forth in the Insurance Code via the Fraud Assessment Commission (FAC) for the prevention of workers compensation insurance fraud. The FAC is involved in assessing and administering a special fund dedicated to this program. Thirty-six counties participated in this program.
2. **Automobile Insurance Fraud Section 1872.8 CIC -** The FD coordinates automobile insurance fraud investigations state-wide. Thirty-four counties participated in this program. Fraudulent activity includes medical mills, organized crime staged accident rings, paper accidents, and organized cart theft conspiracies, as some of the enforcement targets pursued.
3. **Organized Automobile Insurance Fraud Activity Interdiction Program -** Organized automobile fraud activity operating in major urban centers of the state represents a significant portion of all individual fraud-related automobile insurance cases. Nine counties were awarded program grants. Task forces have been established throughout the state comprised of FD personnel, CHP, district attorney offices and allied agencies.
4. **Property/Casualty/Life Program -** This program includes all criminal cases of fraudulent claims arising from other lines of insurance separate from auto and workers' compensation. Funding is derived from an annual assessment per licensed insurance company.
5. **Disability Insurance Fraud Assessment Program** covers Life and Disability Health Insurance. Enforcement is directed to the prevention of fraud in this area of insurance. Five county district attorneys received grants.

Special Investigation Unit Program: The insurance code requires that all insurers doing business within the state maintain "special investigative units" within the insurance company to detect and report suspected fraudulent claims and activity within all lines of insurance written by the company to the Fraud Division. The insurance

company's maintenance of such a unit is governed by regulations, which are periodically updated and reviewed by FLB attorneys.

Internal Affairs: Legal advice and support to the FD Internal Affairs Unit is provided to assist in the confidential investigations of department employees allegedly engaged in some form of impermissible conduct.

Insurance Fraud Advisory Board:

This industry board is comprised of representatives of the Special Investigative Units of a number of insurance carriers. The board makes recommendations as to proposed changes in regulations and legislation. FLB attorneys participate in these meetings.

Qui Tam Civil Actions:

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. This is also known as the False Claims Act. These cases cover a large variety of conduct, including misleading billing practices, and/or fabricated events, products, or services, submitted to a private insurer for payment as a claim. The Commissioner must be served with copies of these lawsuits filed under seal. During the seal period the Commissioner makes a decision whether to intervene in these cases.

Other Civil Actions

Lawsuits are periodically filed against the Department and the FD for conduct arising out of a fraud investigation. FLB attorneys are assigned to provide legal counsel on this litigation.

FLB Workflow: 2009

Matter Type	Matters Opened	Matters Closed	Pending at Year End
Qui Tam Litigation	5	33	16
Legal Opinions	6	4	2
Legislation(analysis of pending bill)	2	2	0
Miscellaneous	17	15	2
Human Resources	3	1	2
Regulation	0	0	0
Civil Litigation	4	1	3
Subpoenas/Public Records	2	2	0
Search Warrants	2	2	0
Oversight	4	0	4
Total:	45	60	29

Government Law Bureau

Statistics by Service Matter Types

Name	Assigned	Closed
Litigation – Defense/Other	28	22
Public Records Act Request	1091	1129
Subpoena	200	328
Substituted Service of Process	29	26
Legislation Oversight	44	45
Regulation Oversight	17	33
Total:	**1409**	**1583**

Office of the Public Advisor

Intervenor applications received in calendar year 2009

- Petition for Hearing, Petition to Intervene & Notice of Intent to Seek Compensation – Insurance Rate/Prior approval matters 6
- Petition to Participate & Notice of Intent to Seek Compensation – regulations matters 1

Intervenor matters closed with grant of compensation

- Cases closed (all rate/prior approval matters) 5
- Amount paid to intervenors by insurers $2,447,125
- Amount paid to intervenors by CDI Prop. 103 Fund $0

Intervenor matters closed with denial of request for compensation..... 0

Intervention matters closed for procedural reasons (no request for compensation submitted, no intervention & therefore no compensation, etc.) 6

Policy Approval Bureau

Policy Approval Statistics: January 1, 2009 to December 31, 2009

Product	Submissions	
	Received	Closed
Group Non-Health	283	191
Supplemental Life	111	73
Fraternal	1	1
Variable Contracts	358	377
Group and Individual Health	575	410
Medicare Supplement	327	308
Unclassified	71	72
Individual Non-Health	82	61
Individual & Group Credit	23	35
Long Term Care	227	205
Workers Compensation	196	169
Sub-Total	**2254**	**1902**
Variable Product Qualifications:		
Variable Annuity -Amend	140	144
Variable Life -Amend	72	72
Variable Annuity	1	0
Variable Life	0	0
Modified Guarantee Annuity	1	1
Sub-Total	**214**	**217**
Other Activities:		
Regulations	1	0
Legal Opinions	2	3
Legislation	3	0
Litigation	6	2
Miscellaneous	6	0
Subpoena	1	1
Others	18	10
Sub-Total	**37**	**16**
TOTAL	**2505**	**2135**

Rate Enforcement Bureau

The Rate Enforcement Bureau 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. Among other things, the Bureau provides legal support to the Department's Rate Regulation Branch. The Bureau provides legal opinions, legislative analyses, responses to public inquiries, legal support in connection with various litigation matters, and promulgates regulations. The Bureau provides legal assistance for issues related to the California Earthquake Authority, the Commissioner's Catastrophe Initiatives, the California Automobile

Assigned Risk Plan, and the California Low Cost Automobile Insurance Program. The Bureau also represents the Department's position in prior approval rate hearings before a Department of Insurance Administrative Law Judge.

A summary of the Bureau's major actions for 2009 is set forth below.

Prior Approval

Petitions for Hearing Received 9

Petitions for Hearing Granted 0

Petitions for Hearing Denied 14

Notices of Hearing Issued 0

Matters Resolved Without Hearing 16

Matters Resolved Following Hearing 1

Matters Pending 4

Rollback

Administrative Cases Pending 1

Rollback Litigation Pending 1

Regulations

Regulation Matters Opened 0

Regulations Approved 3

Civil Litigation

Matters Opened 0

Matters Closed 0

Matters Pending 4

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POLICY AND REGULATIONS BRANCH

Policy and Regulations

The Policy and Regulations Branch includes the: Special Projects Division, Policy Research Division, and Statistical Analysis Division. The Special Projects Division (SPD) supports the Commissioner's Executive Team in analyzing emerging insurance issues with policy implications. SPD also helps implement appropriate Commissioner-directed policy initiatives by assisting regulations projects navigate the requirements of the Administrative Procedure Act. The Statistical Analysis Division (SAD) conducts data calls mandated by statute and regulation, and at the direction of the Executive Team, pursues research on targeted policy issues. SAD identifies and measures trends in the industry in order to support the Commissioner's decision-making process. By integrating policy development, planning, and research, the Policy and Regulations Branch helps solve significant problems faced by consumers, industry, and their respective stakeholders, and responds to the needs of the Governor and Legislature.

Policy Research Division

The Policy Research Division produces studies of proposed and existing public policies affecting the Department of Insurance, consumers and the insurance industry. The Division conducts long-term insurance policy and statistical research, including specialized economic and statistical studies that may guide the Department's regulatory and legislative agenda. These analyses provide the Department with a strong factual foundation that supports the decision-making process.

In 2009, the Policy Research Division's activities included:

- Completing the Division's risk free rate of return project;
- Reviewing of Policy Research Division's prior research related to the auto insurance regulations of the Department of Insurance;
- Providing technical support for the adoption of the California Private Passenger Auto Frequency and Severity Bands Manual regulations;
- Researching the financial soundness of the California insurance market.

Special Projects Division

The Special Projects Division (SPD) supported the Commissioner's policy ideas and initiatives by performing targeted research, analysis, development, and implementation; managing certain communications; and expediting regulations.

Research assignments in 2009 included creating on our public website a catastrophe mitigation page linking to wildfire, earthquake, and flood web pages; addressing steering and related conflicts between automobile body repair dealers and insurers; examining alternative solutions to underinsurance; investigating the possible risks and benefits of utilizing social networking; improving communications to monitor and offer assistance with mandated reports and regulations; and providing legislative bill analysis as requested.

The SPD assisted the CDI's communications flow by managing the daily interaction with the National Association of Insurance Commissioners (NAIC), including distributing the

continuous volume of NAIC information to the appropriate CDI personnel, coordinating CDI's quarterly National meeting participation, and administering the ongoing communication both within CDI (responsibility for attending specific meetings, synopsis reports, grant fund allocation, executive summaries, liaison between NAIC and the Governor's Office, and disseminating meeting information to participating CDI staff for reference) and between the CDI and the NAIC (surveys, inquiries from other state members, meeting/conference details, correspondence on behalf of the Commissioner/CDI Staff).

On behalf of the Policy and Regulations Branch, the SPD communicates with and contributes to the following ongoing department-wide efforts: Green Team, Disability Advisory Committee, Web Content Management Group, Enterprise Information Project Users Group, and the internet and intranet redesign projects. With the assistance of the responsive branches of the CDI, the SPD produced the Commissioner's Annual Report to the Governor and Legislature.

The SPD offers clerical assistance to the team leads of current regulations projects, such as setting up the pre-notice public discussion or subsequent public hearing and researching factual issues. The CDI's list of concluded rulemakings showed eight projects were approved and filed with the Secretary of State in 2009. Also, two changes without regulatory effect were approved in 2009. As of December 31, 2009, the CDI listed 25 current rulemaking projects and 2 prospective rulemaking projects. The SPD also compiles the CDI's Annual Rulemaking Calendar.

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 the Department supports a healthy insurance marketplace and provides California's consumers with information to help them make important insurance decisions.

The SAD maintains databases on a variety of insurance lines. On an annual basis, SAD conducts in-depth analysis on thousands 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 2009, THE 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.
- In collaboration with COIN, Community Development Investments in low to moderate income California communities pursuant to AB925 and as required by California Insurance Code Section 926.2.
- In collaboration with Legal Division, collected data and form filings related to the Language Assistance Program Implementation requirements under California Insurance Code Sections 10133.8 and 10133.9, and California Code of Regulations Title 10, Sections 2538.1 – 2538.8.
- 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.
- Medicare Improvements for Patients and Providers Act Data Call (MIPPA) - Per the Federal Medicare Improvements for Patients and Providers Act of 2008 ((MIPPA) Public Law 110-275). Collected under CIC 700 (C) & CIC 925.4
- Commissioner's Report on Underserved Communities, in accordance with California Code of Regulations 2646.6.
- Automobile Body Repair Inspection Data Call, as required by California Insurance Code Sections 1874.85 and 1874.86.
- 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.
- Long-Term Care Facilities Data Call, as required by California Insurance Code Section 674.9(b).
- Health Assessment Table and Report Development, in accordance with California Insurance Code Section 1872.85.
- Health 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.

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COMMUNITY RELATIONS BRANCH

Community Relations Branch

The Community Relations Branch (CRB) works to proactively connect the California Department of Insurance (CDI) with California consumers. To achieve this mission, CRB 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.

These partnerships facilitate the dissemination of consumer information on complex insurance issues and educate consumers on the availability of programs and consumer protection services available through the CDI. CRB delivers services through the CRB Deputy office, Consumer Education and Outreach Bureau (CEOB), Community Organized Investment Network (COIN) and the Office of the Ombudsman.

Consumer Advisory Task Force

Created in December 2007, the Consumer Advisory Task Force (CATF) was created to establish and maintain an effective line of communication between CDI and California's consumer advocates. In 2009, CATF met multiple times with executive level staff in the various branches at CDI.

Consumer Education and Outreach Bureau

The Consumer Education and Outreach Bureau (CEOB) exists to educate consumers on insurance issues and the availability of CDI as a resource to Californians. CEOB develops and distributes informational guides; coordinates and participates in educational and outreach events as well as provides valuable information to community groups, consumer organizations, small businesses, non-profits, insurance industry organizations and individuals, as well as federal, state and local government agencies.

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

The 2009 calendar year brought significant changes to CEOB. Based on budget restrictions, resources from CEOB were allocated, based on need, to other areas of CDI. In spite of these changes, CEOB still was able to successfully achieve its mission. Throughout the year, CEOB distributed over 200,000 insurance related informational guides and coordinated or participated in more than 180 outreach events throughout the State as follows:

Senior Events 55

Youth/Parent/Faculty 15

Planning Meetings 09

Staff Training/Presentations.....21

Homeowner/Resident 03

Disaster (Wildfire) 07

Insurance Recovery Forums.....04

Community Relations Branch

Consumer Oriented 66

Total Events & Meetings 180

CEOB is responsible for the updating and publication of all insurance consumer information guides for the Department. These guides have been developed as a result of consumer need or to meet statutory provisions. Some 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. In 2009, CRB recognized the culmination of a lengthy effort in the launch of the Senior Information Center on www.insurance.ca.gov. The Senior Information Center contains alerts, advisories and press releases issued by CDI, information on health care plans with links to entities such as the Health Insurance Counseling and Advocacy Program (HICAP), Medicare's Official Site, Department of Aging and other governmental and non-governmental agencies and entities, as well as a senior events calendar and informational guides specific to seniors with a glossary of general insurance terms.

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.

To view the CLCA Annual Report to the Legislature, please visit http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0010-automobile/lca/2010CLCAReport.cfm.

California Organized Investment Network Unit

The mission of the California Organized Investment Network (COIN) Unit is to provide leadership in increasing the level of insurance industry capital in safe and sound investments that provide fair returns to investors and social and economic benefits to traditionally underserved communities. The COIN Unit carries out this mission through two distinct programs; the COIN program itself and the California Community Development Financial Institution (CDFI) Certification and Tax Credit Program.

The COIN program facilitates and encourages the insurance industry to maximize their voluntary investments benefiting California's low-to-moderate income people and communities.

Pursuant to California Insurance Code Section 926.2, insurers admitted to do business in California are required to report the community development investments bi-annually. The latest data call, for 2007 and 2008 calendar years was due to CDI in 2009. As the

data arrived during 2009, the COIN Unit began to analyze the 2007 and 2008. The analysis of this data will be published on CDI's website in 2010.

In addition, the COIN Unit published six COIN Bulletins during 2009. COIN Bulletins are a means of informing insurance companies about some of the many possible investment opportunities which would meet the community development mission of the program. It is a vehicle by which community development organizations actively seeking insurance company investments are able to communicate those needs to the insurance industry. In 2009, COIN posted 6 Bulletins for the community development organizations.

As provided under California Insurance Code Section 12939, the COIN Unit certifies tax credits to California taxpayers making investments meeting certain specification in financial institutions that the COIN Unit has determined meet California's requirements to be designated as a CDFI. During 2009, the COIN Unit certified 23 investments from 18 investors totaling $9.25 million.

Entity	2008	2009
CDC Small Business Finance Corporation	$200,000	
Clearinghouse CDFI	$300,000	$1,750,000
Faith Based Federal Credit Union		$100,000
Low Income Investment Fund	$4,900,000	
Local Initiatives Support Corporation		$300,000
NCB Capital Impact		$5,000,000
Northern California Community Loan Fund	$75,000	$50,000
NHS Neighborhood Lending Services, Inc.	$200,000	$100,000
Neighborhood Housing Services of Orange County	$100,000	$200,000
Opportunity Fund Northern California	$100,000	$350,000
Rural Community Assistant Corporation		$500,000
Santa Cruz Community Credit Union		$100,000
Self-Help Federal Credit Union California Division	$150,000	$750,000
Southern California Reinvestment CDFI	$400,000	$50,000

Finally, during 2009, a CDI sponsored omnibus bill (AB299) passed. The most significant change contained in this legislation was the modification of California Insurance Code Section 1182 to include "insured Credit Unions". Previously, small domestic P&C companies were not authorized to make discretionary investments. Prior law constrained these insurers from making insured and safe deposits in community development credit unions that make high impact investments that help California low income families and communities.

Office of the Ombudsman

The Office of the Ombudsman was created by the Commissioner in 1994, 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 assuring 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 second reviews of cases upon request, focuses the spotlight on areas in need of regulatory reform and carries out special projects to enhance Department communications and streamline operations.

Inquiries to the Ombudsman's office are received by mail, telephone, fax and, increasingly, by e-mail. During 2009, the Ombudsman staff responded to over 1229 requests for assistance.

In addition, the Ombudsman's Office administers the process for the Commissioner's appointments of members to serve on nine boards and committees:

- Advisory Committee on Automobile Insurance Fraud
- Agents and Brokers Advisory Committee
- California Automobile Assigned Risk Plan Advisory Committee
- California Earthquake Authority Governing Board
- California Insurance Guarantee Association Board of Governors
- California Life and Health Insurance Guarantee Association Board of Directors
- California Organized Investment Network Advisory Board
- California Workers' Compensation Insurance Rating Bureau Governing Committee
- Curriculum Board

There were a total of 30 appointments made by the Commissioner in 2009.

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LEGISLATIVE OFFICE

Legislative Office

In 2009, six of the seven department-sponsored bills the Legislative Office (LO) worked on were signed into law. Below are summaries of key bills chaptered in 2009.

- **AB 23 (Jones/Fletcher, Chapter 3)** creates a 65 percent subsidy, provided by the 2009 federal stimulus package, to assist employees who lost their job at a California small business to continue health insurance benefits through COBRA. This bill became effective on May 12, 2009.
- **AB 389 (Saldana, Chapter 101)** allows CDI to monitor the rate increases of older long-term care policies and assures that adequate premium dollars are going to patient care rather than the insurance company. Specifically, the bill provides that at least 70 cents of each premium dollar goes to benefits for the policyholder.
- **AB 601 (Garrick, Chapter 247)** extends the sunset on the 30-cents auto insurance assessment to January 1, 2015. The funds support CDI auto insurance consumer protection and education activities including researching consumer complaints of unfair claims practices, investigating suspected violations of law and conducting outreach efforts for the California Low Cost Automobile Insurance Program.
- **AB 800 (Duvall, Chapter 254)** furthers CDI's ongoing environmental efforts by eliminating wasteful paper transactions. It requires individuals and business entities applying for or renewing licenses to do so online, with specified exceptions, and allows CDI to electronically send license renewal notices to licensees. The bill also aligns several sections of California law with the National Association of Insurance Commissioners licensing requirements.
- **AB 1543 (Assembly Insurance Committee, Chapter 1543)** conforms California's Medigap laws to the federal requirements contained in the Medicare Improvements for Patients and Providers Act of 2008 and the Genetic Information Nondiscrimination Act of 2008. Timely enactment of this bill was necessary to prevent California from being deemed out of compliance and losing its authority to regulate the Medicare market. AB 1543 went into effect on July 2, 2009.

In 2009, LO staff worked with the Information Technology Division and the Department of Managed Health Care to launch the nation's first interactive, consumer-friendly Preferred Provider Organizations (PPO) Report Card on the department's public website. The Report Card allows consumers to compare the state's PPOs in a number of areas such as Diabetes Care, Treating Children, and Heart Care. Each insurer has an overall grade, and consumers can find the components of those grades, down to the individual scores, for dozens of particular best practices. This makes California the first state in the nation to provide a PPO quality of care report card.

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COMMUNICATIONS AND PRESS RELATIONS BRANCH

The Communications/Press Relations Office

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

The Communications/Press Relations Office also collaborates with the Community Relations Branch and Consumer Services and Market Conduct Branch 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. Notably, the Communications responsibility is to deliver information which is crucial in representing the message of the Insurance Commissioner and the Department.

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EXECUTIVE OPERATIONS

Information Assurance and Organizational Accountability Office

(IA&OAO) provides management of the Department with independent, objective, accurate and timely information necessary to make policy decisions. The IA&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 IA&OAO is independent and team-oriented, committed to providing timely, professional, and objective services to satisfy customer needs. The IA&OAO takes personal responsibility for its work by meeting the standards of professional competence.

The IA&OAO is composed of four distinct functions with eight staff members reporting to the Chief Deputy Commissioner:

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

Internal Audits Unit

The **Internal Audits Unit** 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 conducts a Department-wide Risk Assessment and 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 IA&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.

Information Security Office

The **Information Security Office** (ISO) is responsible for investigating breaches in physical and data security, filing incident reports to the Department of Information Technology Division as well as reviewing data recovery procedures. The ISO is also responsible jointly with the Internal Audits Unit for undertaking a Risk Analysis Management Program (RAMP) survey of all critical/sensitive information assets to determine which are at greater risk and to develop a plan for greater security. To accomplish the investigation, filing and review of data recovery procedures, the ISO coordinates with technology staff to resolve any potential security issues. Information

security means the protection of information and information systems, equipment, and people from a wide spectrum of threats and risks. The ISO also implements appropriate security measures and controls to provide for the confidentiality, integrity, and availability of all information, regardless of its form (electronic, print, or other media) which is critical to ensure business continuity and protection against unauthorized access, use, disclosure, disruption, modification, or destruction.

Business Process Reengineering Unit

The **Business Process Reengineering Unit** was created in 2009 to provide pertinent and meaningful world-class solutions to the department. Specifically, the Unit can conduct preliminary Needs Assessment of each branch's business processes to identify resource requirements of the branch, and make recommendations for the testing, implementation, and monitoring of proposed business process redesign efforts based on the individual needs assessments. 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, and presents alternatives and makes recommendations to management on methods to achieve improved business process efficiencies and effectiveness for each business process; reviews, updates and analyzes processes for the analyses of risks associated with agency information assets. 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 audit or information security staff; provides formal training on Information Security, 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 **Ethics Office** (Office) was created in 2000 to provide private, secure and confidential communications and investigations. The Office receives and researches complaints regarding employees' conflicts with the Political Reform Act and the Department's Incompatible Activities Statements 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 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.

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 Department's goal of being the single best consumer service protection agency in the nation. In 2008, the OCR began the objective of moving the office to a more discrete location and implementing a policy of handling all complaints internally, with the few exceptions where a conflict of interest may exist. In 2009, the OCR successfully implemented these objectives which has drastically cut operating expenses and encouraged a positive working relationship with staff at all levels within the CDI. The OCR continues to promotes an open door policy to ensure that CDI employees feel comfortable knowing that they may contact the OCR about any issue at any time, which has played a role in encouraging employees to report possible violations of the Department's policy to CDI first, thereby reducing the number of complaints initially reported to outside State and federal agencies.

Training

In 2010 the OCR will concentrate on updating CDI civil rights policies, developing and disseminating training on sexual harassment prevention, equal employment opportunity principals (AB1825) and respect and professionalism in the workplace to all CDI staff.

American's with Disabilities Act (ADA) Compliance

In addition, the OCR is responsible for the Department's compliance with the ADA. This responsibility includes the designation of an ADA Coordinator and grievance procedures for consumers to ensure that the Department's programs, services and activities are as effective and accessible to those consumers with disabilities as to others without disabilities. Below is a summary of the OCR requirements and oversight:

- Develop policy prohibiting discrimination of employees and consumers with disabilities,
- Develop and maintain procedures to provide reasonable modifications, alternative formats, auxiliary aids and services to consumers with disabilities,
- Implement policy requiring documents and website are accessible to persons with disabilities,
- Develop and provide ADA Notice and Grievance Procedures advising the public of their ADA rights and procedures for them to voice Departmental Title II violations,
- Train and assist front line staff in current ADA standards.
- Monitor and respond to consumer questions and complaints through CDI's on-line ADA Compliance Mailbox.

To ensure that there are no barriers to disabled consumers in accessing CDI facilities, services, or information, staff throughout CDI diligently work to identify and correct

barriers within programs and services in order to anticipate and accommodate any request from the disabled public. In addition, CDI has in place a public ADA Compliance mailbox on our website for consumers to speak directly to the OCR staff about any compliance issue or concern they may have.

EEO Staffing

Currently, the OCR Office has two permanent positions- the Equal Employment Opportunity (EEO) Officer, who is also CDI's ADA Coordinator, and an EEO Investigator. These two positions have allowed OCR staff to conduct internal investigations and cut costs on contracts to outside investigators.

Mediation Services

In 2010 the OCR will develop and implement an in-house mediation pilot program for CDI employees. Mediation is a useful tool in dispute resolution. The programs objective is to encourage active communication and participation of all involved parties to disentangle office conflict and assist in team building. The CDI mediation program will follow similar state personnel board rules/guidelines in identifying viable mediation requests for services and implementing program objectives.

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 2009, 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 2009 include the following:

- prior approval of disputed rate change applications in Proposition 103 lines of insurance (Ins. Code Section 1861.05),
- 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),
- appeals from decisions of California Insurance Guarantee Association ("CIGA") (Ins. Code Section 1067.10).

In 2009, the AHB opened 41 cases and closed 47 cases.[1] In addition, the AHB presided over a Rate Roll Back matter that was remanded to the AHB:

Case Type	Opened	Closed
Prior Approval	0	3
Workers' Compensation Appeals	41	47
CIGA	2	1

[1]*The number includes case closures that occurred in 2009 on files that were opened during 2008.*