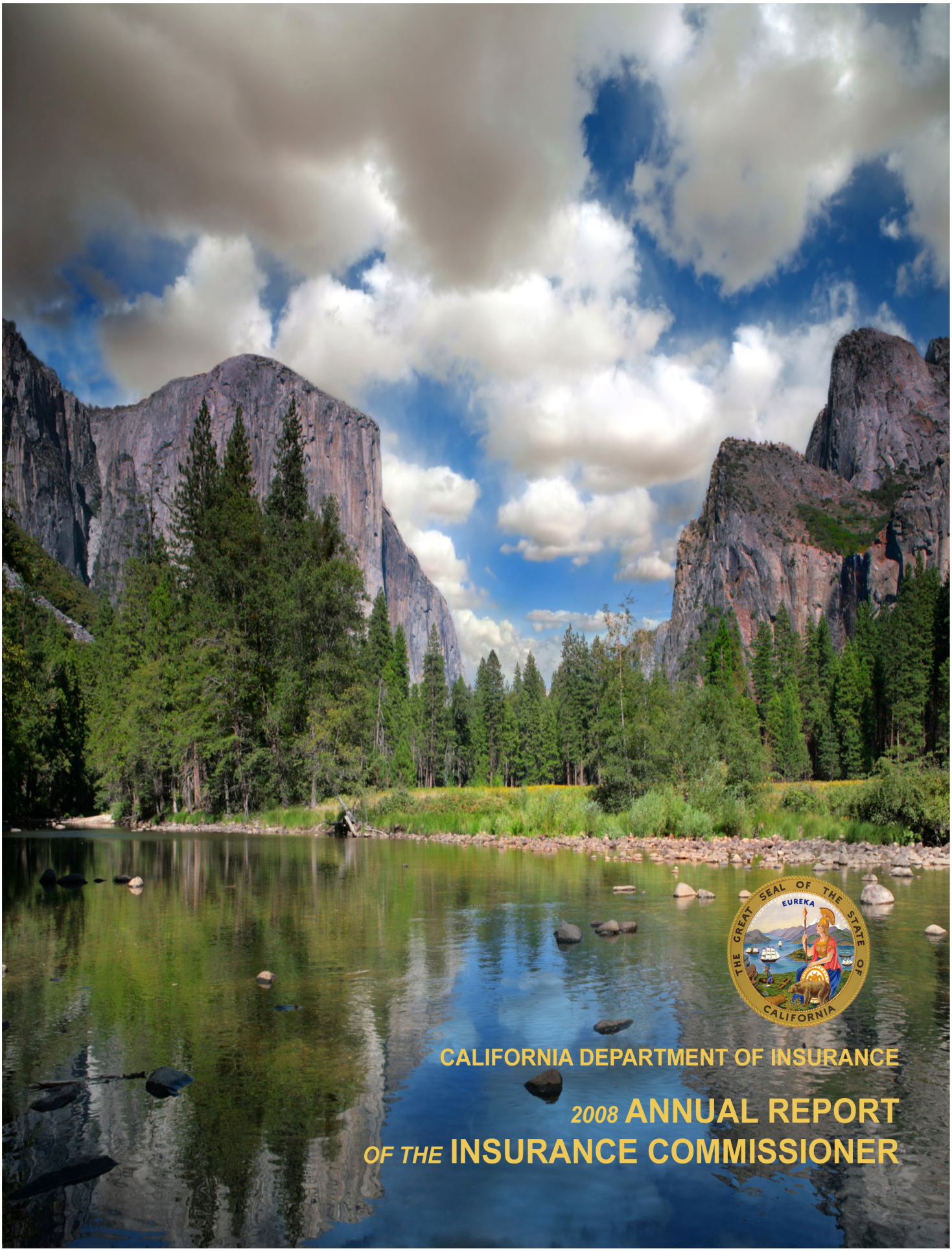

CALIFORNIA DEPARTMENT OF INSURANCE

2008 ANNUAL REPORT *OF THE* INSURANCE COMMISSIONER

STATE OF CALIFORNIA Steve Poizner, *Insurance Commissioner*

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(916) 492-3500
(916) 445-5280 (FAX)
www.insurance.ca.gov

July 31, 2009

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

Dear Governor Schwarzenegger:

I am pleased to provide you the *2008 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;
- §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

California Department of Insurance
2008 Organizational Chart (Graphical Version)

INSURANCE COMMISSIONER

CHIEF OF STAFF

CHIEF DEPUTY OF OPERATIONS

CONSERVATION & LIQUIDATION OFFICE

ADMINISTRATION & LICENSING SERVICES

Financial Management
Business Management
Human Resources Management
Licensing Services
Information Technology

RATE REGULATION

Rate Filing Bureaus (5)
Actuarial Unit
Rate Specialist

CONSUMER SERVICES & MARKET CONDUCT

Market Conduct
Consumer Services

FINANCIAL SURVEILLANCE

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

ENFORCEMENT

Fraud
Investigations

INTERNAL WORKING GROUPS

ADMINISTRATIVE ASSISTANT TO THE COMMISSIONER

COMMUNICATIONS & PRESS RELATIONS

LEGISLATIVE OFFICE

LEGAL/CHIEF COUNSEL

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

POLICY & REGULATIONS

Policy Research
Statistical Analysis
Special Projects (formerly Policy Initiatives)
Workers' Compensation Insurance Policy Advisor
Homeowner's Insurance Policy Advisor

COMMUNITY RELATIONS

Low Income Community Outreach
Low Cost Auto

EXECUTIVE OPERATIONS

Executive Office
Ethics & Operational Compliance
Office of Civil Rights (formerly EEO/AA Compliance)
Office of the Ombudsman
Administrative Hearing Bureau
California Organized Investment Network
Office of Market Competition

California Department of Insurance
2008 Organizational Chart (Accessible Text Version)

INSURANCE COMMISSIONER

- CHIEF OF STAFF
- CHIEF DEPUTY OF OPERATIONS
  - CONSERVATION & LIQUIDATION OFFICE

CHIEF OF STAFF

ADMINISTRATIVE ASSISTANT TO THE COMMISSIONER

COMMUNICATIONS & PRESS RELATIONS

LEGISLATIVE

LEGAL/GENERAL COUNSEL

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

POLICY & REGULATIONS

- Policy Research
- Statistical Analysis
- Special Projects Division (formerly Policy Initiatives Office)
- Workers' Compensation Insurance Policy Advisor
- Homeowner's Insurance Policy Advisor

COMMUNITY RELATIONS

- Low Income Community Outreach
- Low Cost Auto

EXECUTIVE OPERATIONS

- Executive Office
- Ethics & Operational Compliance
- Office of Civil Rights (formerly EEO/AA Compliance)
- Office of Ombudsman
- Administrative Hearing Bureau
- California Organized Investment Network
- Office of Market Competition
- Office of Strategic Planning

CHIEF DEPUTY OF OPERATIONS

ADMINISTRATION & LICENSING SERVICES

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

RATE REGULATION

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

CONSUMER SERVICES & MARKET CONDUCT

- Market Conduct
- Consumer Services

FINANCIAL SURVEILLANCE

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

ENFORCEMENT

- Fraud
- Investigations

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2008 ANNUAL REPORT

CONSERVATION & LIQUIDATION OFFICE

CONSERVATION & LIQUIDATION OFFICE

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Section 2 – Estate Specific Information

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Section 1 – The Conservation & 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 insolvent 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.

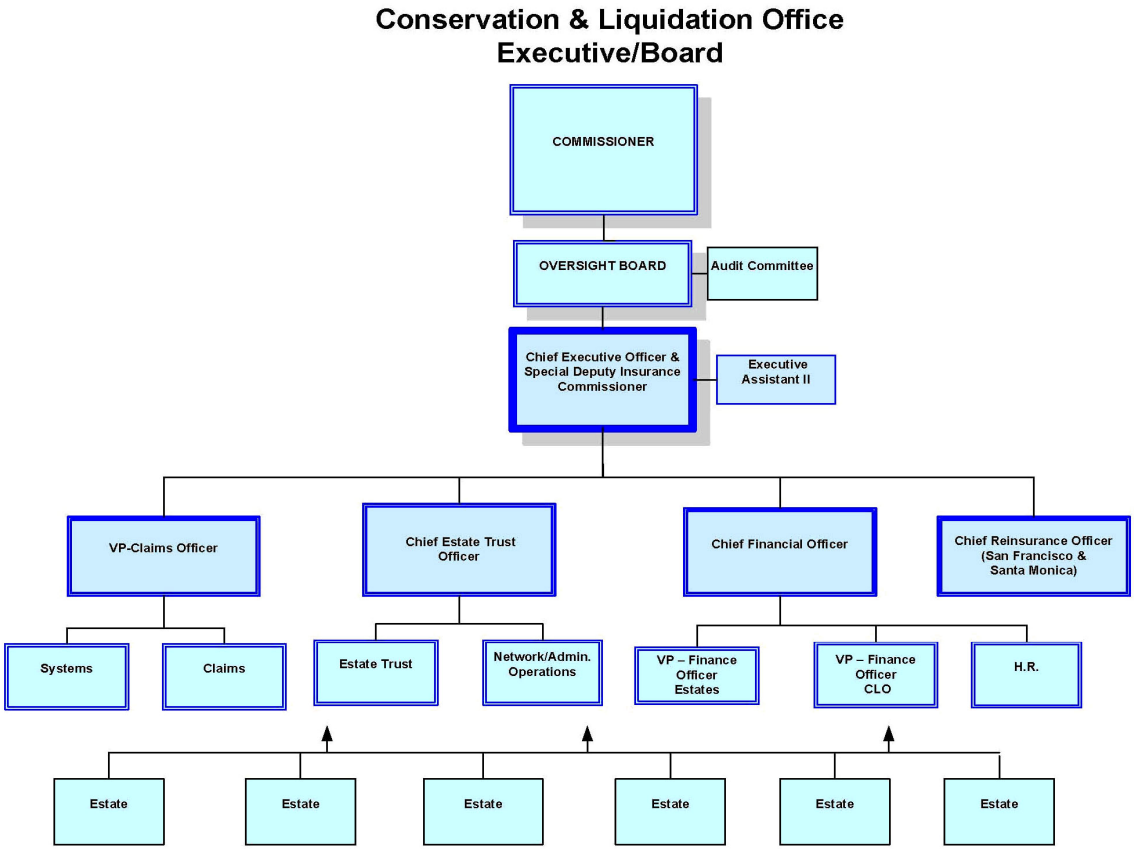
If, at the time the conservation order is issued or anytime thereafter, it appears to the Commissioner that it would be futile to proceed with the conservation of the financially troubled estate, the Commissioner will apply for an order to liquidate the estate's business. In response to the Commissioner's 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, 2008, the CLO was responsible for the administration of 26 insolvent insurance estates.

Organizational Structure



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

Organization Structure of Conservation and Liquidation Office Executive/Board

- Commissioner
  - Oversight Board
    Audit Committee
    - Chief Executive Officer & Special Deputy Insurance Commissioner
      Executive Assistant II
      - VP-Claims Officer
        - Systems
        - Claims
      - Chief Estate Trust Officer
        - Estate Trust
        - Network/Admin Operations
      - Chief Financial Officer
        - VP – Finance Officer Estate
        - VP – Finance Officer CLO
        - Human Resources
      - Chief Reinsurance Officer (San Francisco and Santa Monica)

All Estates (currently 26 remain open) are administered by the Conservation & Liquidation Office (CLO) through the organizational chart.

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 Jim Richardson, Chief of Staff, Adam Cole, Deputy Commissioner and General Counsel, and Ramon Calderon, Deputy Commissioner-Financial Surveillance. The Committee meets on a quarterly basis throughout the year.

During 2008, the Oversight Board and Audit Committee held four regularly scheduled meetings and two special purpose meetings. There was 100% attendance by the Committee members at all meetings.

2008 Organizational Goals and Results

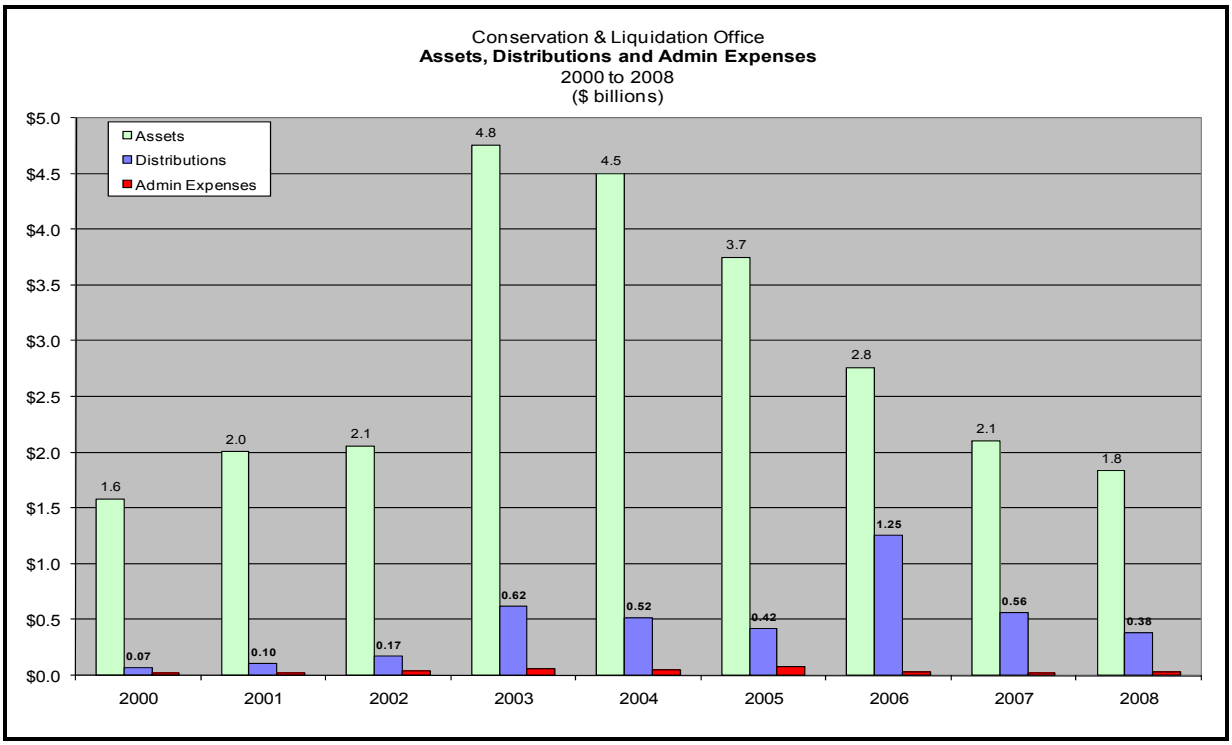
On an annual basis, the CLO prepares a business plan for the organization supporting the CLO Mission Statement. The Business Plan is then submitted to the Board for approval. The CLO's Mission Statement is as follows:

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 2008 Business Plan was a continuation of the objectives of the 2007 Business Plan, focusing on estate closings and distributions and enhancing the operating efficiencies of the CLO.

Entering 2008, 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 2008 was to close three estates and distribute $164 million.

In addition to the Business Plan for the organization, 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 Board on a quarterly basis.



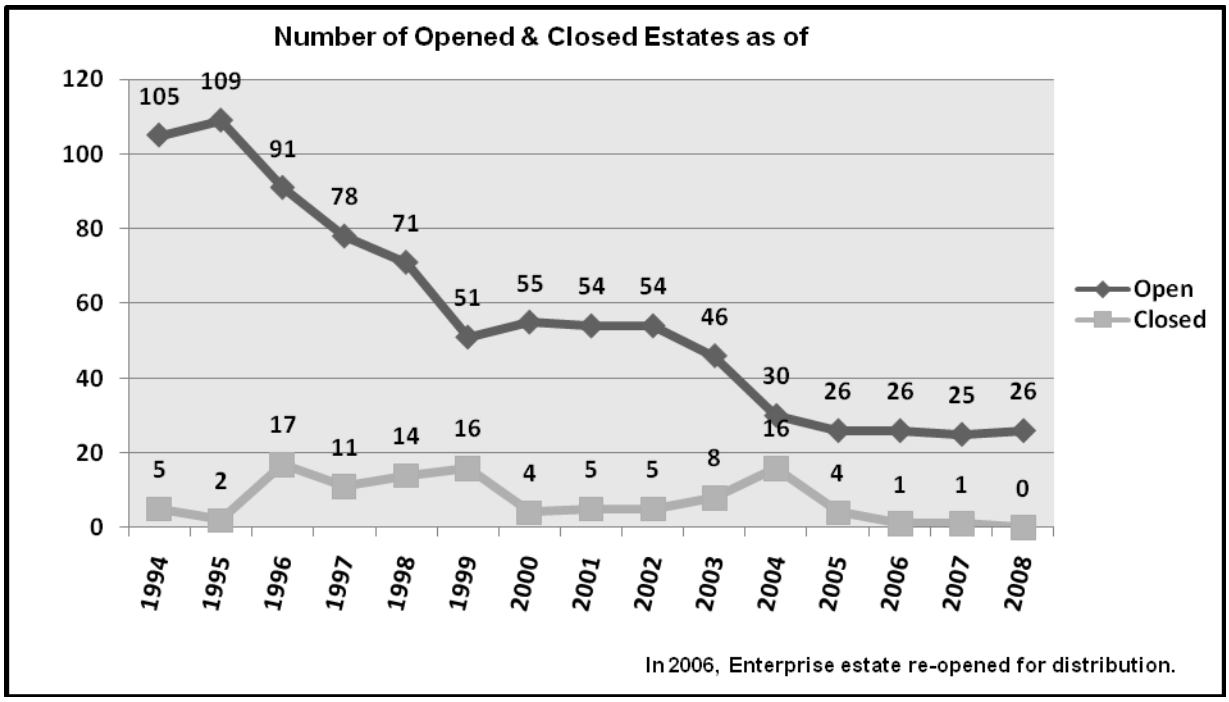
The chart above displays the Conservation & Liquidation Office Assets, Distributions and Admin Expenses from the year 2000 to 2008.The table below lists these figures which are in billions.

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

The 2008 goals and results are as follows:

1. Closings

GOAL	RESULTS
Close 3 Estates: 1) Citation 2) Paula 3) Western Growers	No estates were closed during 2008. Three estates had final distributions in 2008 and will formally close in 2009. One estate targeted for closure, Citation, has a contingent tax issue with its parent company. In 2008, Citation distributed all available funds, except for a tax reserve.



The chart above lists the number of opened and closed Estates for the following years:

1994 – Opened 105, Closed 5; 1995 – Opened 109, Closed 2; 1996 – Opened 91, Closed 17; 1997 – Opened 78, Closed 11; 1998 – Opened 71, Closed 14; 1999 – Opened 51, Closed 16; 2000 – Opened 55, Closed 4; 2001 – Opened 54, Closed 5, 2002 – Opened 54, Closed 5; 2003 – Opened 46, Closed 8; 2004 – Opened 30, Closed 16; 2005 – Opened 26, Closed 4; 2006 – Opened 26, Closed 1; 2007 – Opened 25, Closed 1; 2008 – Opened 26, Closed 0.

*In 2006, Enterprise estate re-opened for distribution.

Since 1994, there have been approximately 117 estates closed. These estates consisted of 55 ancillaries, 22 title companies, and 40 “regular” insurers. Ancillary and title companies typically require limited work on behalf of the liquidator.

2. Distributions

Early Access Distributions

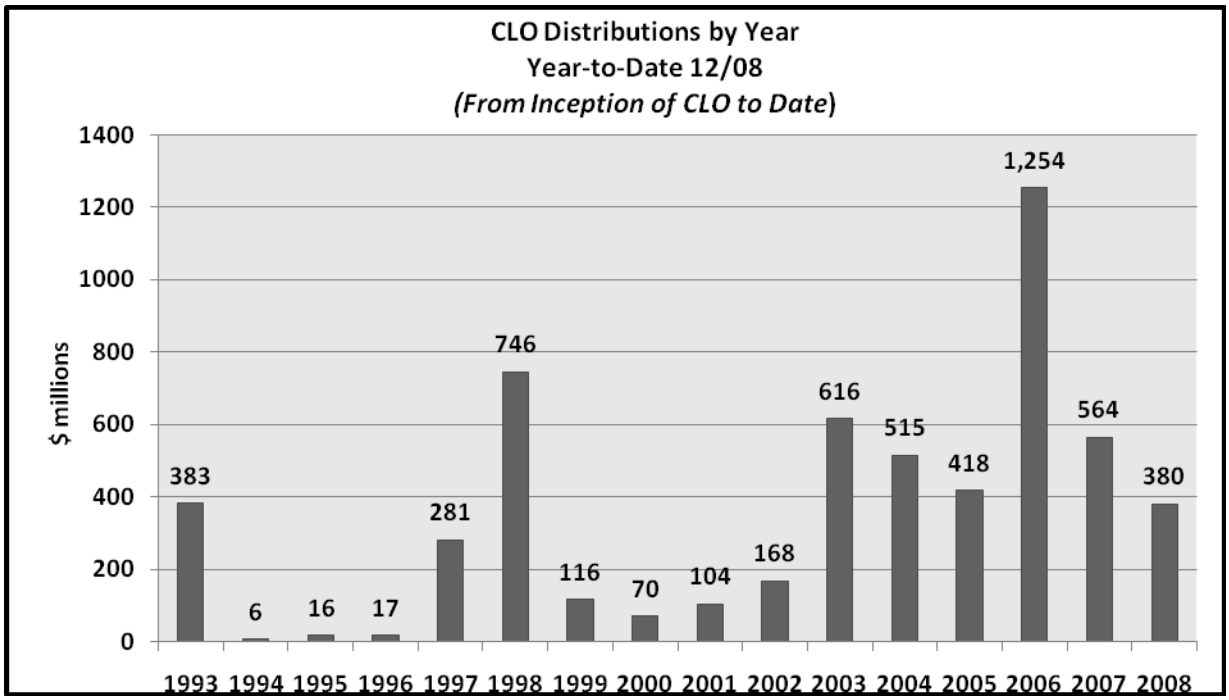
Distributions	2008 Actual ($Millions)	2008 Goal ($Millions)
Fremont	$ 50	$ 50
Superior National	88	25
Sub-total:	**138**	**75**

Final Distributions

Distributions	2008 Actual ($Millions)	2008 Goal ($Millions)
Paula	$53	$42
National Auto	0	20
Western Growers	16	15
Western International	10	0
Sub-total:	**79**	**77**

Interim Distributions

Distributions	2008 Actual ($Millions)	2008 Goal ($Millions)
Mission, Cash	$123	$0
Mission, Covanta Stock Distribution	32	0
Citation	8	12
Sub-total:	**163**	**12**
Total Distributions:	**$380**	**$164**



The chart above lists the CLO distributions Year-to-date 12/08 (from inception of CLO to Date). The figures are by year and 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, 418; 2006, 1254; 2007, 564; 2008, 380.

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. ex Baa which was 19 months at December 31, 2008.

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, 2008, the CLO had $575 million of estate marketable investment securities under management.

For the year ending December 31, 2008, the average portfolio balance was approximately $705 million. The portfolio earned an interest yield of 4.3% and a net yield after security gains/losses and mark-to-market adjustments of 2.2%.

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. For example, if employees charged 200 hours to a specific estate and in total charged 2,000 hours to 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.

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.

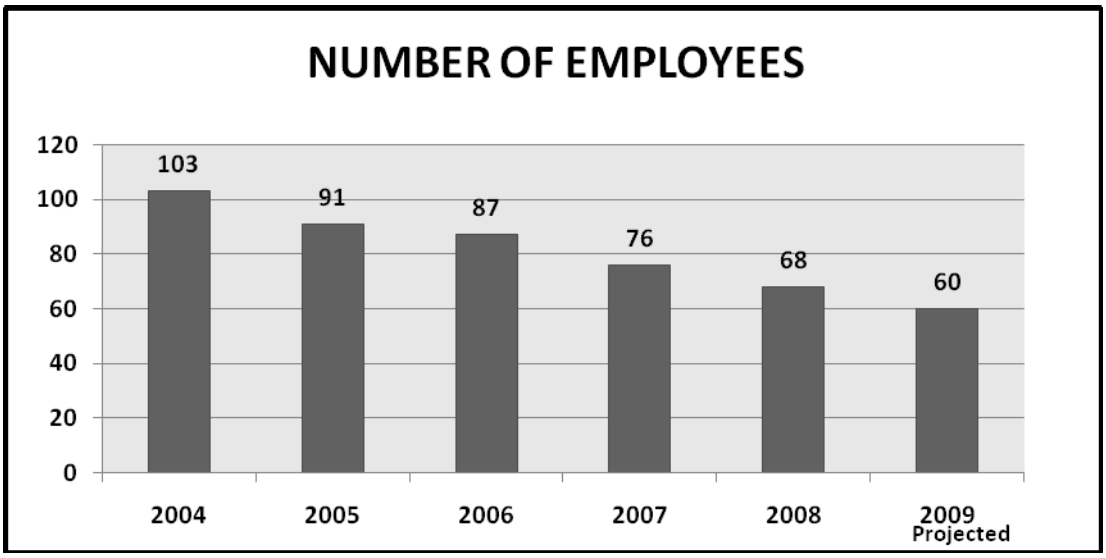
A summary of the compensation procedures follows:

- 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:

[1] See "Combined Financial Results" section of this report on the budget, and actual expenditures for 2008 for direct and indirect expenses.

	31-Dec-07	31-Dec-08
Number of CLO employees	76	68
Total compensation for CLO employees	$ 7,816,889	$ 7,320,399

As estates have closed resulting in reduced workloads and, as a result of internal operating efficiencies, the number of full-time employees decreased by 10.4% in 2008 compared to 2007, and by 34.0% compared to December 31, 2004.



The chart above shows the number of CLO employees from 2004 to 2009:

2004, 103; 2005, 91; 2006, 87; 2007, 76; 2008, 68; 2009, 60 projected.

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 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, organizations similar in size to the CLO, and located in San Francisco.

CLO Financial Results

For Years Ended December 31, 2008 and December 31, 2007

Cash received	December 31, 2008		December 31, 2007
	Actual	Budget	
Litigation and reinsurance recoveries	$ 96,658,600	N/A[2]	$ 101,840,600
Investment income, net of expenses	26,137,800	N/A[3]	74,198,400
Total:	**$ 122,796,400**		**$ 176,039,000**

[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, 2008		December 31, 2007
	Actual	Budget	
Distributions	**$ 380,151,900**	**$ 164,000,000**	**$ 563,579,300**

Administrative – Estate Direct Expenses

Estate Direct Expenses	December 31, 2008		December 31, 2007
	Actual	Budget	
Legal expenses	$ 8,934,200	$ 9,007,400	$ 1,993,300[4]
Consultants and contractors	2,580,600	2,979,100	3,694,200
Office expenses	2,441,000	2,248,900	2,482,700
Compensation and benefits	863,300	730,400	937,600
Total	**14,819,100**	**14,965,800**	**9,107,800**

[4]*Estate direct legal expenses in 2007 were $6.5 million before a $4.5 million reimbursement from an arbitration settlement.*

Administrative – CLO Overhead Expenses

CLO overhead expenses	December 31, 2008		December 31, 2007
	Actual	Budget	
Compensation and benefits	7,320,300	7,290,800	7,816,900
Office expenses	2,695,400	2,895,600	2,802,200
Consultants and contractors	711,800	909,400	931,700
Legal expenses	14,100	55,300	26,800
Total	**10,741,600**	**11,151,100**	**11,577,600**

Administrative Totals	December 31, 2008		December 31, 2007
	Actual	Budget	
Estate Direct Expense Total	**14,819,100**	**14,965,800**	**9,107,800**
CLO Overhead Expense Total	**10,741,600**	**11,151,100**	**11,577,600**
Total:	**$ 25,560,700**	**$ 26,116,900**	**$ 20,685,400**

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 post- 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[5] 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.

[5]*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 been set for retrial in late 2009. 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 $683 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/ WEIC of California:

These estates wrote coverage on very long-tail exposures (asbestos, tobacco, etc.) and have 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.

Western International:

The estate wrote business primarily in the southern California market and covered various commercial business interests. The company became embroiled in a five year legal dispute between the Board of Directors and a senior executive over employment terms. Ultimately the subject executive prevailed in court and was awarded a default judgment of more than $25 million against WIIC. Settlement of the award was accomplished in 1992. At the time of WIIC was struggling financially. The settlement payment technically rendered the company insolvent based upon the results of a regulatory exam. Shortly after payment was rendered "LA Riots" occurred.

Losses attributable to various acts of violence and vandalism were disputed by reinsurers who argued the proper interpretation of the treaty coverage. The main issue was the determination of a common understanding of what constitutes the number of "occurrences" when dealing with a general, wide spread riot. The contracts did not define a clear occurrence in circumstances of catastrophic loss; "What is a riot or how many instances make a riot?" This legal definition drives the calculation of amounts due from the reinsurer.

Considerable efforts were made to provide reinsurers with documentation of amounts billed on non-riot related losses. Reinsurers refused to pay these losses until they were satisfied with the available premium data. After considerable time the Liquidator determined the optimum approach to resolution with reinsurers in settling with WIIC was to consolidate all issues and data into "commutation packages".

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	1,106	1,106	0	1
Frontier Pacific	11/30/2001	33,631	33,628	3	2
Fremont	7/2/2003	45,047	42,658	2,389	49
Fremont Life			Not liquidated		
Golden Eagle[6]	2/1/1998		n/a (see below)		
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	6/21/2002	10,720	10,720	0	0
Paula Superior (5 estates)	9/26/2000	13,885	13,883	2	61
Sable	7/17/2001	378	378	0	4
Western Employers (2 estates)	4/19/1991	9,228	8,919	309	48
Western Growers	1/17/2003	2	2	0	0
Western International	9/9/1992	19,936	19,936	0	0
	Total:	**318,927**	**316,223**	**2,704**	**198**

[6] *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: All open estates, except Citation and Paula, 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.

Life Insurance Estate

Executive Life Insurance Company 327,000 policies/contracts

2009 Business Goals

The 2009 Business Plan is a continuation of the objectives of the 2008 Business Plan, focusing on estate closings and distributions and enhancing the operating efficiencies. Entering 2009, there are 26 open estates in liquidation under management by the CLO. The open estates consist of 23 Property & Casualty Estates, one Workers' Compensation and two Life/Health Estates. Our goal in 2009 is to close five estates and distribute $100 million.

Starting 2009, we have 68 full-time employees and 9 temporary employees. We will continue a planned reduction in staff during 2009. The planned reduction will be approximately 9%, which is the primary result from the closure of the Fremont Los Angeles reinsurance operation. 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 26 estates.

The 2009 Goals are as follows:

1. Close 5 Estates[7]
   - Paula
   - Western Growers
   - Western Employers Insurance Co. of America
   - Enterprise
   - Western International

2. Early Access and Final Distributions

Early Access Distributions:	
Fremont	$ 50,000,000
Final Distributions:	
Enterprise	4,000,000
National Auto	23,000,000
Western Employers Ins. Co. of America	10,000,000
Sable	13,000,000
	50,000,000
	$100,000,000

[7] *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 2008

Fremont Life Ins. Co. was conserved on June 5, 2008.

Conservation or Liquidation Estates Closed During the Year 2008

No Estates were closed in 2008.

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

	Year Ended 12/31/2008				Cumulative to 12/31/2008			
Estate Name	Policy-holders	Federal & State Claims Having Preference	General Creditors	Total	Policy-holders	Federal & State Claims Having Preference	General Creditors	Total
Alistar Insurance Company					$8,073			$8,073
California Compensation Insurance Company	$26,814			$26,814	441,218			441,218
Citation General Insurance Company	7,478			7,478	17,133			17,133
Combined Benefits Insurance Company					17,216			17,216
Commercial Compensation Casualty Company	437			437	47,983			47,983
Enterprise Insurance Company					120,573	$40	$411	121,024
Executive Life Insurance Company					737,276			737,276
Fremont Indemnity Insurance Company	49,863			49,863	810,153			810,153
Fremont Life Insurance Company								
Frontier Pacific Insurance Company								
Golden Eagle Insurance Company								
Great States Insurance Corporation	101			101	10,151			10,151
HIH America Insurance Company					279,669			279,669
Mission Insurance Company	10,133		$44,674	54,807	846,630	111	207,251	1,053,992
Mission National Insurance Company	99,860		838	100,698	499,607		27,077	526,684
Municipal Mutual Insurance Company								
National Automobile & Casualty Insurance Company					391			391
Pacific National Insurance Company					23,416			23,416
Paula Insurance Company	53,147			53,147	139,008			139,008
Sable Insurance Company					6,661			6,661
Superior National Insurance Company	55,912			55,912	164,251			164,251
Superior Pacific Casualty Company	4,969			4,969	30,600			30,600
Western Employers Insurance Company					63,030			63,030
Western Employers Insurance Company of America					1,639			1,639
Western Growers Insurance Company	15,514			15,514	18,101			18,101
Western International Insurance Company	10,412			10,412	27,412			27,412
Total	$334,640	$0	$45,512	$380,152	$4,310,191	$151	$234,739	$4,545,081

Estates in Conservation and/or Liquidation as of December 31, 2008

Estate Name	Date Conserved	Date Liquidation
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	02/01/98
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
Paula Insurance Company	04/26/02	06/21/02
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
Western Employers Insurance Company of America	04/25/91	05/07/91
Western Growers Insurance Company	*	01/17/03
Western International Insurance Company	08/10/92	09/09/92

**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 this Section 2 provides a summary of the 2008 operating goals and results, the current status of the Estates in the conservation or liquidation process, and summarized financial information[8].

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.

[8]*Each of the estates under management of the CLO has 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)*

Estate Specific Information

Alistar Insurance Company
Conservation Order: April 11, 2002
Liquidation Order: October 24, 2002

2008 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. Additionally the estate had significant accounts receivable assets (premium and subrogation) to be recovered.

During 2008, the Estate's goal was to bill active reinsurance treaties and to position the remaining reinsurance agreements for commutation. The Reinsurance Department is 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 2010 and close the estate thereafter subject to any escheatment requirements.

Conservation & Liquidation Office

Alistar Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$10,938,100	$11,810,300
Recoverable from reinsurers	5,632,700	4,727,800
Other assets	13,700	6,000
Total assets	16,584,500	16,544,100

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	289,800	285,700
Claims against policies, before distributions	36,390,900	43,810,100
Less distributions to policyholders	(8,073,200)	(8,073,200)
All other claims	108,400	111,000
Total liabilities	28,715,900	36,133,600
Net assets (deficiency)	($12,131,400)	($19,589,500)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$540,500	$211,500
Litigation recoveries	1,000,000	
Salvage and other recoveries	339,600	215,100
Total income	1,880,100	426,600

Expenses	2007	2008
Loss and claims expenses	1,111,100	7,653,500
Administrative expenses	447,600	229,800
Total expenses	1,558,700	7,883,300
Net income (loss)	$321,400	($7,456,700)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$13,361,500
Recoveries, net of expenses	6,522,000
Distributions	(8,073,200)
Monetary assets available for distribution	$11,810,300

Citation General Insurance Company
Conservation Order: July 21, 1995
Liquidation Order: August 24, 1995

2008 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 2008, the Estate's goal was to resolve all asset collections, determine final estate liabilities (subject to ultimate tax exposure) and release an interim distribution to policyholder claimants for approximately $7.5 million. These goals were accomplished.

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 2009.

Conservation & Liquidation Office

Citation General Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$18,434,600	$11,448,200
Recoverable from reinsurers	249,500	86,600
Other assets	1,200	900
Total assets	18,685,300	11,535,700

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	5,364,500	5,869,000
Claims against policies, before distributions	18,136,500	17,956,600
Less distributions to policyholders	(9,655,000)	(17,132,700)
All other claims	1,810,400	1,812,600
Total liabilities	15,656,400	8,505,500
Net assets (deficiency)	$3,028,900	$3,030,200

INCOME AND EXPENSES

Income	2007	2008
Investment income	$1,058,200	$254,900
Litigation recoveries		
Salvage and other recoveries	3,000	600
Total income	1,061,200	255,500

Expenses	2007	2008
Loss and claims expenses	382,400	390,000
Administrative expenses	247,000	269,000
Total expenses	629,400	659,000
Net income (loss)	$431,800	($403,500)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$8,744,200
Recoveries, net of expenses	19,836,700
Distributions	(17,132,700)
Monetary assets available for distribution	$11,448,200

Executive Life Insurance Company
Conservation Order: April 11, 1991
Liquidation Order: December 6, 1991

2008 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 decided 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 has been set for November 3, 2009.

Depending on the outcome, 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. During this same period, 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. This matter is ongoing in spite of several court-ordered mediation and meet and confer attempts by the parties to amicably settle the issue at hand.

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 amicably settle this dispute but hope to do so as soon as possible. Previously allotted policyholder funds are being held until resolution of this issue.

Based on BSA's recommendation, the Commissioner is awaiting agreement from Aurora National Assurance Company, Inc. and 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.

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 is conducting research in this area with a view to settling this matter. A reserve has been set up to deal with this issue.

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 results of the appeal in the Commissioner's civil lawsuit against Artemis et al is finalized. This trust 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 will then be remitted to the SCO in August 2009, to accommodate the SCO regulations. The Holdback Trust is to be closed by September 2009. 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 will then be remitted to the SCO in December 2009, to accommodate the SCO regulations. At that time, the financial statements will be provided from inception to close and an application will be made to the court to terminate the trust and discharge the Commissioner as trustee.

Executive Life Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments, unrestricted	42,815,000	43,125,200
Restricted investments, NOLHGA	9,224,200	9,379,900
Restricted investments, Opt-In Only	694,900	490,100
Restricted investments, Aurora-Penn	5,787,400	5,878,200
Other assets	1,653,400	1,653,400
Total assets	60,174,900	60,526,800

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	7,887,600	8,167,000
Claims against policies, before distributions	2,998,670,700	2,998,670,700
Less distributions to policyholders	(737,275,900)	(737,275,900)
All other claims	428,800	428,800
Total liabilities	2,269,711,200	2,269,990,600
Net assets (deficiency)	($2,209,536,300)	($2,209,463,800)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$10,695,800	$3,758,400
Litigation recoveries		
Salvage and other recoveries		
Total Income	10,695,800	3,758,400

Expenses	2007	2008
Loss and claims expenses		
Administrative expenses [9]	(1,207,000)	2,073,200
Total expenses	(1,207,000)	2,073,200
Net income (loss)	$11,902,800	$1,685,200

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION [10]

Beginning monetary assets at takeover	$112,111,400
Recoveries, net of expenses	684,037,900
Distributions	(737,275,900)
Monetary assets available for distribution	58,873,400

9 Executive Life administrative expenses in 2007 were $3.3 million before $4.5 million reimbursed by NOLHGA for attorney fees and other litigation expenses.

10 This schedule represents changes in assets available for distribution from August 1, 1997, when Executive Life's estate accounting was transferred to the CLO, to December 31, 2008.

ELIC Holdback Trust

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$1,717,400	$1,776,700
Other assets		
Total assets	1,717,400	1,776,700

Liabilities	12/31/2007	12/31/2008
Secured claims	71,800	
Unclaimed funds payable	1,048,200	1,147,900
Reserve for administrative expenses	597,400	628,800
Total liabilities	1,717,400	1,776,700
Net assets (deficiency)	$0	$0

INCOME AND EXPENSES

Income	2007	2008
Investment income	$120,300	$33,600
Litigation recoveries		
Salvage and other recoveries		
Total income	120,300	33,600

Expenses	2007	2008
Loss and claims expenses		
Administrative expenses	67,300	100
Total expenses	67,300	100
Net income (loss)	$53,000	$33,500

Conservation & Liquidation Office

ELIC Opt Out Trust

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$21,190,300	$21,349,500
Other assets		
Total assets	21,190,300	21,349,500

Liabilities	12/31/2007	12/31/2008
Secured claims	16,531,300	17,814,900
Unclaimed funds payable	2,788,300	2,477,700
Reserve for administrative expenses	1,870,700	1,056,900
Total liabilities	21,190,300	21,349,500
Net assets (deficiency)	$0	$0

INCOME AND EXPENSES

Income	2007	2008
Investment income	$411,500	$429,700
Litigation recoveries		
Salvage and other recoveries		
Total income	411,500	429,700

Expenses	2007	2008
Loss and claims expenses		
Administrative expenses	319,500	74,000
Total expenses	319,500	74,000
Net income (loss)	$92,000	$355,700

Fremont Indemnity Company
Conservation Order: June 04, 2003
Liquidation Order: July 02, 2003

2008 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 is expected to rest in March of 2009. The estate seeks damages in excess of $150M. The Estate's parent company, FGC, filed for protection under Chapter 11 of the Bankruptcy Code in June of 2008. As such the Estate must seek financial recovery for the use of its net operating losses through the proof of claim process in the bankruptcy court. Counsel for the estate has filed four proofs of claims. The Commissioner continues to assess any opportunity to settle both cases.

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 San Francisco staff will complete the balance of the run off of the reinsurance program.

The Estate completed its fifth early access distribution in 2008, and continues to refine the magnitude of the policyholder claims that are not covered by the guaranty associations.

The Estate anticipates releasing its sixth early access distribution during 2009, or it may seek to make an interim distribution to all approved Policyholder Class creditors if the non-covered exposure can be reliably quantified.

Conservation & Liquidation Office

Fremont Indemnity Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$110,549,200	$134,918,300
Recoverable from reinsurers	263,744,200	168,264,100
Other assets	65,863,900	59,939,600
Total assets	440,157,300	363,122,000

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	21,902,700	24,464,000
Claims against policies, before distributions	2,340,291,600	2,397,240,800
Less distributions to policyholders	(760,289,700)	(810,153,300)
All other claims	341,076,100	393,751,700
Total liabilities	1,942,980,700	2,005,303,200
Net assets (deficiency)	($1,502,823,400)	($1,642,181,200)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$14,815,000	$5,532,900
Litigation recoveries	420,000	265,900
Salvage and other recoveries	6,618,600	15,412,000
Total income	21,853,600	21,210,800

Expenses	2007	2008
Loss and claims expenses	151,068,600	148,144,700
Administrative expenses	9,862,400	12,458,400
Total Expenses	160,931,000	160,603,100
Net income (loss)	($139,077,400)	($139,392,300)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$434,855,900
Recoveries, net of expenses	510,215,700
Distributions	(810,153,300)
Monetary assets available for distribution	$134,918,300

Fremont Life Insurance Company
Conservation Order: June 05, 2008

2008 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. It is expected to require most of 2009 to complete the formal assumption process and to resolve the remaining of contractual disputes associated with litigation existing at the time of conservation.

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

Assets	12/31/2008
Cash and investments	$1,458,200
Recoverable from reinsurers	
Other assets	209,300
Total assets	1,667,500

Liabilities	12/31/2008
Secured claims and accrued expenses	153,000
Claims against policies, before distributions	
Less distributions to policyholders	
All other claims	258,500
Total liabilities	411,500
Net assets (deficiency)	$1,256,000

INCOME AND EXPENSES

Income	2008
Investment income	$40,900
Litigation recoveries	
Salvage and other recoveries	173,100
Total income	214,000

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

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$1,443,100
Recoveries, net of expenses	15,100
Distributions	
Monetary assets available for distribution	$1,458,200

Frontier Pacific Insurance Company
Conservation Order: September 7, 2001
Liquidation Order: November 30, 2001

2008 Report

Frontier Pacific Insurance Company ("FPIC"), a California domiciled property and casualty company was licensed in California, Nevada, New York and South Carolina. Frontier Pacific 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, certain reinsurance recoverables due FPIC from FIC were never paid to FPIC. A subsequent financial examination by the California regulators disallowed the FIC reinsurance receivable resulting in a negative surplus on FPIC's books. The "Claims Bar Date", or the final date to submit a claim against the Estate, was August 30, 2002.

During conservation, the Commissioner determined that FPIC's financial condition was such that rehabilitation was futile and the Order of Liquidation was sought and obtained shortly thereafter. 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 to the appropriate parties, 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 affect release to the appropriate parties, including escheatment. The Liquidator has reached an agreement with the New York Liquidator on a procedure for the disposition of collateral securing joint and several obligations of FPIC and FIC.

The Liquidator is also continuing to collaborate with the New York Liquidation Bureau to reconcile and collect on many 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.

Unable to negotiate a reasonable resolution to the NICO dispute, the Estate has filed a Declaratory Relief action to determine the Estate's obligations associated with its reinsurance-relationship to NICO. The Court ruled in favor of NICO, staying the prosecution of FPIC's claims. The Estate has subsequently filed a Motion for Reconsideration of the court's ruling. The Court has scheduled a hearing date in March 2009 to consider the matter once again.

Resolution of the NICO and FIC reinsurance relationships is the final requirement to position the Estate for a final distribution and closure.

Conservation & Liquidation Office

Frontier Pacific Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$19,937,300	$19,220,200
Recoverable from reinsurers	47,002,800	46,737,600
Other assets	1,480,500	1,450,100
Total assets	68,420,600	67,407,900

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	612,600	791,800
Claims against policies, before distributions	53,530,800	53,653,800
Less distributions to policyholders		
All other claims	22,784,400	22,675,000
Total liabilities	76,927,800	77,120,600
Net assets (deficiency)	($8,507,200)	($9,712,700)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$1,048,800	$384,100
Litigation recoveries		
Salvage and other recoveries	(81,800)	26,700
Total income	967,000	410,800

Expenses	2007	2008
Loss and claims expenses	(3,337,600)	700,600
Administrative expenses	968,100	915,900
Total expenses	(2,369,500)	1,616,500
Net income (loss)	$3,336,500	($1,205,700)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$18,531,900
Recoveries, net of expenses	688,300
Distributions	
Monetary assets available for distribution	$19,220,200

Golden Eagle Insurance Company

Conservation Order:	**January 31, 1997**
Rehab./Liquidation Plan Approved:	**August 4, 1997**
Liquidation Order:	**February 13, 1998**

2008 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.

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 a claim against the Estate, was February 27, 1998.

As part of the Rehabilitation Plan, the Trust purchased sufficient reinsurance coverage to cover the remaining workers' compensation exposure 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 Golden Eagle Trust was officially closed on March 28, 2007.

As all 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, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$2,049,600	$2,031,600
Recoverable from reinsurers		
Other assets		
Total assets	2,049,600	2,031,600

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses		1,100
Claims against policies, before distributions		
Less distributions to policyholders		
All other claims		
Total liabilities		1,100
Net assets (deficiency)	$2,049,600	$2,030,500

INCOME AND EXPENSES

Income	2007	2008
Investment income	$86,200	$54,800
Litigation recoveries		
Salvage and other recoveries		11,900
Total income	86,200	66,700

Expenses	2007	2008
Loss and claims expenses		
Administrative expenses	70,400	85,700
Total expenses	70,400	85,700
Net income (loss)	$15,800	($19,000)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover [11]	$2,029,000
Recoveries, net of expenses	2,600
Distributions	
Monetary assets available for distribution	$2,031,600

[11] *As of December 31, 2006, when Golden Eagle's estate accounting was transferred to the CLO.*

HIH America Compensation & Liability Insurance Company
Conservation Order: March 30, 2001
Liquidation Order: May 8, 2001

2008 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 all balances. Additionally, the Estate had a significant reinsurance program that was placed under a multi-year 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.

The Estate has resolved all agreements allowing for the release of all statutory deposits to the states they are held in benefit for. The final agreement with the State of Missouri has been settled and funds are to be released in 2009.

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 Superior Access 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 the Estate. HIH Hawaii and the Estate have sought and received approvals in their respective liquidation courts. Settlement proceeds will be transferred to the Estate after the appeal period expires in March 2009.

The Estate's immediate goal is to resolve the final inter-company balance with the Australia parent company, collect the final reinsurance recoveries in 2009, and seek to release a final distribution by 2010.

HIH America Compensation & Liability Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$46,481,600	$48,413,400
Recoverable from reinsurers	1,626,300	1,994,700
Other assets	22,669,800	20,764,500
Total assets	70,777,700	71,172,600

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	44,100	246,300
Claims against policies, before distributions	646,677,900	674,214,700
Less distributions to policyholders	(279,669,300)	(279,669,300)
All other claims	2,118,800	1,399,700
Total liabilities	369,171,500	396,191,400
Net assets (deficiency)	($298,393,800)	($325,018,800)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$2,621,100	$907,800
Litigation recoveries		1,485,100
Salvage and other recoveries	2,702,000	1,990,800
Total income	5,323,100	4,383,700

Expenses	2007	2008
Loss and claims expenses	13,880,100	31,097,300
Administrative expenses	1,086,500	582,400
Total expenses	14,966,600	31,679,700
Net income (loss)	($9,643,500)	($27,296,000)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$147,637,800
Recoveries, net of expenses	180,444,900
Distributions	(279,669,300)
Monetary assets available for distribution	$48,413,400

Great States Insurance Company
Conservation Order: March 30, 2001
Liquidation Order: May 8, 2001

2008 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 balance of treaties remaining, approximately $50,000 in amounts due, will be written off or sold if the reinsurers refuse to settle. The Estate cannot justify the administrative expense to keep the Estate open for the amounts outstanding.

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

Conservation & Liquidation Office

Great States Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$6,677,400	$6,772,200
Recoverable from reinsurers	14,374,100	10,590,600
Other assets		
Total assets	21,051,500	17,362,800

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	29,000	24,400
Claims against policies, before distributions	76,808,000	79,800,600
Less distributions to policyholders	(10,050,200)	(10,151,300)
All other claims	11,917,600	11,917,600
Total liabilities	78,704,400	81,591,300
Net assets (deficiency)	($57,652,900)	($64,228,500)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$363,000	$116,600
Litigation recoveries		
Salvage and other recoveries	4,137,800	67,900
Total income	4,500,800	184,500

Expenses	2007	2008
Loss and claims expenses	8,340,900	6,523,200
Administrative expenses	231,800	237,200
Total expenses	8,572,700	6,760,400
Net income (loss)	($4,071,900)	($6,575,900)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$7,889,700
Recoveries, net of expenses	9,033,800
Distributions	(10,151,300)
Monetary assets available for distribution	$6,772,200

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

2008 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, only the general creditors to 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.

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 early 2009 to release another payment to its general creditors. Both the Mission and Mission National Estates will also consider what cash is available for distribution in 2009.

Conservation & Liquidation Office

Mission Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$140,205,500	$88,859,500
Recoverable from reinsurers	10,809,500	10,603,100
Other assets	71,627,600	78,083,400
Total assets	222,642,600	177,546,000

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	79,057,000	79,337,800
Claims against policies, before distributions	839,159,700	846,832,600
Less distributions to policyholders	(836,192,900)	(846,629,600)
All other claims	301,581,400	256,851,600
Total liabilities	383,605,200	336,392,400
Net assets (deficiency)	($160,962,600)	($158,846,400)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$14,993,400	$3,581,200
Litigation recoveries		
Debt forgiveness income		915,746,800
Salvage and other recoveries	11,300	1,078,300
Total income	15,004,700	920,406,300

Expenses	2007	2008
Loss and claims expenses	(36,864,400)	916,963,900
Administrative expenses	653,800	1,326,200
Total expenses	(36,210,600)	918,290,100
Net income (loss)	$51,215,300	$2,116,200

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$133,667,000
Recoveries, net of expenses	1,009,184,400
Distributions	(1,053,991,900)
Monetary assets available for distribution	$88,859,500

Conservation & Liquidation Office

Mission National Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$116,733,000	$18,120,400
Recoverable from reinsurers	1,079,200	1,079,200
Other assets	173,900	147,300
Total assets	117,986,100	19,346,900

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	16,528,600	17,743,000
Claims against policies, before distributions	399,174,100	596,098,500
Less distributions to policyholders	(399,747,100)	(499,606,700)
All other claims		16,838,100
Total liabilities	15,955,600	131,072,900
Net assets (deficiency)	$102,030,500	($111,726,000)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$7,154,700	$1,192,900
Litigation recoveries		
Debt forgiveness income		75,397,400
Salvage and other recoveries	137,600	49,300
Total income	7,292,300	76,639,600

Expenses	2007	2008
Loss and claims expenses		289,998,400
Administrative expenses	154,200	397,700
Total expenses	154,200	290,396,100
Net income (loss)	$7,138,100	($213,756,500)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$18,289,000
Recoveries, net of expenses	526,515,500
Distributions	(526,684,100)
Monetary assets available for distribution	$18,120,400

Conservation & Liquidation Office

Enterprise Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$1,982,900	$6,319,500
Recoverable from reinsurers		
Other assets		
Total assets	1,982,900	6,319,500

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	1,094,800	1,094,600
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	35,632,800
Total liabilities	36,727,600	36,727,400
Net assets (deficiency)	($34,744,700)	($30,407,900)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$155,500	$69,800
Litigation recoveries		
Salvage and other recoveries		1,669,800
Total income	155,500	1,739,600

Expenses	2007	2008
Loss and claims expenses		(2,613,400)
Administrative expenses	32,100	16,100
Total expenses	32,100	(2,597,300)
Net income (loss)	$123,400	$4,336,900

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$3,281,000
Recoveries, net of expenses	124,062,500
Distributions	(121,024,000)
Monetary assets available for distribution	$6,319,500

Municipal Mutual Insurance Company
Supervision Agreement Date: **August 18, 2003**
Liquidation Order: **October 31, 2006**

2008 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 approximately $1.2 million in 2008 and will continue to pursue commutations in 2009.

Conservation & Liquidation Office

Municipal Mutual Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$312,700	$1,245,100
Recoverable from reinsurers	1,672,800	1,137,400
Other assets		
Total assets	1,985,500	2,382,500

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	26,200	24,500
Claims against policies, before distributions	7,757,600	8,742,700
Less distributions to policyholders		
All other claims		
Total liabilities	7,783,800	8,767,200
Net assets (deficiency)	($5,798,300)	($6,384,700)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$15,800	$7,800
Litigation recoveries		
Salvage and other recoveries	67,500	4,400
Total income	83,300	12,200

Expenses	2007	2008
Loss and claims expenses	6,073,800	510,300
Administrative expenses	151,600	88,100
Total expenses	6,225,400	598,400
Net income (loss)	($6,142,100)	($586,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$920,200
Recoveries, net of expenses	324,900
Distributions	
Monetary assets available for distribution	$1,245,100

National Automobile & Casualty Insurance Company
Conservation Order: March 15, 2002
Liquidation Order: April 23, 2002

2008 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 2008, the Estate's goal was to complete the adjudication of all general creditors POCs. All POCs have been adjudicated, with the exception of one POC, which is currently in dispute. The Estate is monitoring the resolution of an "off-set" dispute emanating from the sale of certain assets from the Estate. Upon resolution, the Estate will finalize its total liability and seek to complete a final distribution in 2009.

Conservation & Liquidation Office

National Automobile Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$24,549,000	$24,731,100
Recoverable from reinsurers		
Other assets		
Total assets	24,549,000	24,731,100

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	311,200	289,800
Claims against policies, before distributions	22,155,100	22,143,400
Less distributions to policyholders	(391,500)	(391,500)
All other claims	4,954,100	5,055,800
Total liabilities	27,028,900	27,097,500
Net assets (deficiency)	($2,479,900)	($2,366,400)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$1,380,800	$465,700
Litigation recoveries		
Salvage and other recoveries	505,800	(123,800)
Total income	1,886,600	341,900

Expenses	2007	2008
Loss and claims expenses	(879,100)	(39,300)
Administrative expenses	369,900	291,600
Total expenses	(509,200)	252,300
Net income (loss)	$2,395,800	$89,600

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$13,264,000
Recoveries, net of expenses	11,858,600
Distributions	(391,500)
Monetary assets available for distribution	$24,731,100

Pacific National Insurance Company
Conservation Order: May 14, 2003
Liquidation Order: August 5, 2003

2008 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 2008, the Estate's goal was to finalize an actuarial study to commence commutation proposals in 2009.

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

Conservation & Liquidation Office

Pacific National Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$13,289,600	$14,866,900
Recoverable from reinsurers	7,195,400	9,285,500
Other assets	6,400	
Total assets	20,491,400	24,152,400

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	109,000	5,530,000
Claims against policies, before distributions	104,292,600	108,126,500
Less distributions to policyholders	(23,416,400)	(23,416,400)
All other claims	(884,900)	239,300
Total liabilities	80,100,300	90,479,400
Net assets (deficiency)	($59,608,900)	($66,327,000)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$717,800	$259,400
Litigation recoveries		
Salvage and other recoveries	196,700	758,400
Total income	914,500	1,017,800

Expenses	2007	2008
Loss and claims expenses	2,007,000	6,349,000
Administrative expenses	337,000	255,600
Total expenses	2,344,000	6,604,600
Net income (loss)	($1,429,500)	($5,586,800)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$36,519,100
Recoveries, net of expenses	1,764,200
Distributions	(23,416,400)
Monetary assets available for distribution	$14,866,900

Paula Insurance Company
Conservation Order: April 26, 2002
Liquidation Order: June 21, 2002

2008 Report

Paula Insurance Company, a wholly-owned subsidiary of Paula Financial, wrote Workers' Compensation coverage for labor-intensive agri-businesses located in eight states. All Paula policies were cancelled as of July 21, 2002. The "Claims Bar Date", or the final date to submit a claim against the Estate, was March 31, 2003.

The Estate has a significant reinsurance program that was in run-off over a number of years. Additionally, the Estate pursued significant premium collections after conducting final audits on certain programs (policies). The Estate concluded asset collections (including final reinsurance commutations) and settled all IGA claims in 2007.

During 2008, the Estate's goal was to complete a final distribution to approved claimants. In September 2008, the estate completed its final distribution to six IGAs and 400 claimants for approximately $53 million.

The Estate's ultimate goal is to complete its escheatment requirements and file a Declaration of Compliance to close the estate in 2009.

Conservation & Liquidation Office

Paula Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$53,709,300	$623,800
Recoverable from reinsurers		
Other assets	361,200	288,700
Total assets	54,070,500	912,500

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	61,700	788,100
Claims against policies, before distributions	274,641,200	274,626,700
Less distributions to policyholders	(85,861,200)	(139,008,200)
All other claims	292,600	290,000
Total liabilities	189,134,300	136,696,600
Net assets (deficiency)	($135,063,800)	($135,784,100)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$3,190,200	$783,700
Litigation recoveries		
Salvage and other recoveries	1,625,500	241,400
Total income	4,815,700	1,025,100

Expenses	2007	2008
Loss and claims expenses	(21,516,700)	839,400
Administrative expenses	960,500	865,000
Total expenses	(20,556,200)	1,704,400
Net income (loss)	$25,371,900	($679,300)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$83,802,000
Recoveries, net of expenses	55,830,000
Distributions	(139,008,200)
Monetary assets available for distribution	$623,800

Sable Insurance Company
Conservation Order: May 10, 2001
Liquidation Order: July 17, 2001

2008 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 consists 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, determine ultimate liability, and position the Estate for a final distribution in 2009. 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. The cost to keep the Estate open beyond the immediate estate plan may not be justified.

Conservation & Liquidation Office

Sable Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$15,014,100	$15,116,200
Recoverable from reinsurers	308,200	291,100
Other assets	4,700	4,700
Total assets	15,327,000	15,412,000

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	361,200	1,558,200
Claims against policies, before distributions	52,193,200	52,306,000
Less distributions to policyholders	(6,661,400)	(6,661,400)
All other claims	18,600	185,800
Total liabilities	45,911,600	47,388,600
Net assets (deficiency)	($30,584,600)	($31,976,600)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$841,900	$284,100
Litigation recoveries		
Salvage and other recoveries	748,600	158,200
Total income	1,590,500	442,300

Expenses	2007	2008
Loss and claims expenses	(507,600)	1,587,600
Administrative expenses	281,500	246,900
Total expenses	(226,100)	1,834,500
Net income (loss)	$1,816,600	($1,392,200)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$17,472,300
Recoveries, net of expenses	4,305,300
Distributions	(6,661,400)
Monetary assets available for distribution	$15,116,200

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

2008 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 California Insurance Guarantee Association (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. The Appeal was heard on November 19, 2008 and both parties are awaiting the Court's opinion. U.S. Life has posted a surety bond in the amount of $600 million to preclude the Commissioner from executing on judgment.

The Commissioner has filed an application for an order authorizing the Commissioner to draw on U.S. Life's Special Schedule P Deposit, and to make a distribution to the 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. The Court ruled in favor of the Commissioner's application and $53 million was released to CIGA in February 2009.

A sixth Early Access Distribution to IGAs totaling approximately $32 million was made in June 2008. Since liquidation of the SNICIL companies, the total Early Access Distributions to IGAs amount to approximately $472 million.

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 2009. The Estate's ultimate goal is to resolve its reinsurance program, complete final asset recoveries and position the Estate for closure.

Conservation & Liquidation Office

California Compensation Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$65,926,100	$41,687,300
Recoverable from reinsurers	389,073,500	378,240,400
Other assets	354,500	143,100
Total assets	455,354,100	420,070,800

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	3,176,400	28,390,000
Claims against policies, before distributions	1,616,506,400	1,745,533,800
Less distributions to policyholders	(414,404,000)	(441,217,600)
All other claims	117,747,200	120,683,500
Total liabilities	1,323,026,000	1,453,389,700
Net assets (deficiency)	($867,671,900)	($1,033,318,900)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$4,287,700	$1,040,200
Litigation recoveries		
Salvage and other recoveries	25,689,000	7,928,600
Total income	29,976,700	8,968,800

Expenses	2007	2008
Loss and claims expenses	(29,081,800)	169,373,200
Administrative expenses	2,126,400	2,321,900
Total expenses	(26,955,400)	171,695,100
Net income (loss)	$56,932,100	($162,726,300)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$165,879,200
Recoveries, net of expenses	317,025,700
Distributions	(441,217,600)
Monetary assets available for distribution	$41,687,300

Conservation & Liquidation Office

Combined Benefits Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$3,087,400	$2,703,200
Recoverable from reinsurers	11,541,300	12,064,400
Other assets	3,100	
Total assets	14,631,800	14,767,600

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	24,100	415,900
Claims against policies, before distributions [12]	29,406,800	25,581,700
Less distributions to policyholders	(17,215,900)	(17,215,900)
All other claims	4,092,800	3,590,600
Total liabilities	16,307,800	12,372,300
Net assets (deficiency)	($1,676,000)	$2,395,300

INCOME AND EXPENSES

Income	2007	2008
Investment income	$223,400	$46,100
Litigation recoveries		
Salvage and other recoveries	1,338,100	16,200
Total income	1,561,500	62,300

Expenses	2007	2008
Loss and claims expenses	(1,177,300)	(3,932,400)
Administrative expenses	90,800	89,300
Total expenses	(1,086,500)	(3,843,100)
Net income (loss)	$2,648,000	$3,905,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$11,115,400
Recoveries, net of expenses	8,803,700
Distributions	(17,215,900)
Monetary assets available for distribution	$2,703,200

[12] *The Estate continues to be subject to reserve adjustment as future losses are considered by the affected guaranty associations.*

Conservation & Liquidation Office

Superior National Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$21,203,300	$21,798,700
Recoverable from reinsurers	175,270,100	184,940,400
Other assets	382,000	232,300
Total assets	196,855,400	206,971,400

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	1,883,000	7,123,700
Claims against policies, before distributions	758,579,300	730,358,600
Less distributions to policyholders	(108,339,400)	(164,251,500)
All other claims	28,629,500	28,747,300
Total liabilities	680,752,400	601,978,100
Net assets (deficiency)	($483,897,000)	($395,006,700)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$1,030,400	$717,400
Litigation recoveries	600	
Salvage and other recoveries	19,294,900	58,376,300
Total income	20,325,900	59,093,700

Expenses	2007	2008
Loss and claims expenses	38,192,400	34,237,600
Administrative expenses	1,084,700	1,030,200
Total expenses	39,277,100	35,267,800
Net income (loss)	($18,951,200)	$23,825,900

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$68,622,300
Recoveries, net of expenses	117,427,900
Distributions	(164,251,500)
Monetary assets available for distribution	$21,798,700

Conservation & Liquidation Office

Superior Pacific Casualty Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$9,762,700	$6,632,900
Recoverable from reinsurers	21,587,300	22,367,700
Other assets	43,100	400
Total assets	31,393,100	29,001,000

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	11,000	1,648,900
Claims against policies, before distributions	161,772,800	169,027,700
Less distributions to policyholders	(25,630,600)	(30,600,400)
All other claims	68,312,700	68,312,700
Total liabilities	204,465,900	208,388,900
Net assets (deficiency)	($173,072,800)	($179,387,900)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$691,300	$135,500
Litigation recoveries		
Salvage and other recoveries	2,339,600	306,800
Total income	3,030,900	442,300

Expenses	2007	2008
Loss and claims expenses	40,415,500	6,509,200
Administrative expenses	385,800	417,600
Total expenses	40,801,300	6,926,800
Net income (loss)	($37,770,400)	($6,484,500)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$58,666,300
Recoveries, net of expenses	(21,433,000)
Distributions	(30,600,400)
Monetary assets available for distribution	$6,632,900

Conservation & Liquidation Office

Commercial Compensation Casualty Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$3,800,500	$3,307,200
Recoverable from reinsurers	43,421,200	45,528,500
Other assets	111,500	28,800
Total assets	47,333,200	48,864,500

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	594,000	1,696,600
Claims against policies, before distributions	126,322,500	125,811,900
Less distributions to policyholders	(47,545,800)	(47,982,800)
All other claims	10,731,900	11,578,500
Total liabilities	90,102,600	91,104,200
Net assets (deficiency)	($42,769,400)	($42,239,700)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$215,800	$65,000
Litigation recoveries		
Salvage and other recoveries	2,487,300	1,718,800
Total income	2,703,100	1,783,800

Expenses	2007	2008
Loss and claims expenses	(2,327,000)	30,200
Administrative expenses	132,900	110,300
Total expenses	(2,194,100)	140,500
Net income (loss)	$4,897,200	$1,643,300

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$6,420,700
Recoveries, net of expenses	44,869,300
Distributions	(47,982,800)
Monetary assets available for distribution	$3,307,200

Western Employers Insurance Company
Conservation Order: April 2, 1991
Liquidation Order: April 19, 1991

Western Employers Insurance Company of America
Conservation Order: April 25, 1991
Liquidation Order: May 7, 1991

2008 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.

Western Employers Insurance Company of American ("WEICA") is a wholly-owned subsidiary of WEIC. WEICA was licensed in eight states, with its principal place of business located in Fullerton, California. The company wrote only Workers' Compensation insurance. WEICA was included in its parent company's self-liquidation process. The "Claims Bar Date", or the final date to submit a claim against the Estates, was November 15, 1991.

Plans to determine WEICA's total estate liability, make a final distribution, and close the estate, have been implemented. The final distribution and closure are planned in 2009. This will not impair the ability to finalize tasks necessary to close the WEIC parent estate.

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 should sufficient assets be available at final distribution, the Estate will also consider making an interest payment to approved claimants.

Conservation & Liquidation Office

Western Employers Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$105,056,500	$108,868,100
Recoverable from reinsurers	19,141,000	18,644,400
Other assets	10,332,100	10,332,000
Total assets	134,529,600	137,844,500

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	10,500	3,200
Claims against policies, before distributions	205,252,100	176,653,400
Less distributions to policyholders	(63,029,700)	(63,029,700)
All other claims	3,479,500	6,329,100
Total liabilities	145,712,400	119,956,000
Net assets (deficiency)	($11,182,800)	$17,888,500

INCOME AND EXPENSES

Income	2007	2008
Investment income	$5,623,200	$2,203,200
Litigation recoveries		
Salvage and other recoveries	90,100	90,500
Total income	5,713,300	2,293,700

Expenses	2007	2008
Loss and claims expenses	86,796,500	(27,354,800)
Administrative expenses	712,400	577,100
Total expenses	87,508,900	(26,777,700)
Net income (loss)	($81,795,600)	$29,071,400

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$74,867,900
Recoveries, net of expenses	97,029,900
Distributions	(63,029,700)
Monetary assets available for distribution	$108,868,100

Western Employers Insurance Company of America

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$11,404,300	$11,135,800
Recoverable from reinsurers		
Other assets	200	
Total assets	11,404,500	11,135,800

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	100	1,100
Claims against policies, before distributions	1,891,500	1,891,300
Less distributions to policyholders	(1,639,300)	(1,639,300)
All other claims	10,332,000	10,332,000
Total liabilities	10,584,300	10,585,100
Net assets (deficiency)	$820,200	$550,700

INCOME AND EXPENSES

Income	2007	2008
Investment income	$634,000	$95,700
Litigation recoveries		
Salvage and other recoveries		
Total income	634,000	95,700

Expenses	2007	2008
Loss and claims expenses	900	
Administrative expenses	38,100	365,200
Total expenses	39,000	365,200
Net income (loss)	$595,000	($269,500)

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$7,293,500
Recoveries, net of expenses	5,481,600
Distributions	(1,639,300)
Monetary assets available for distribution	$11,135,800

Western Growers Insurance Company
Liquidation Order: January 17, 2003

2008 Report

On January 17, 2003, the Orange County Superior Court entered an Order of Liquidation for Western Growers Insurance Company. WGIC wrote Workers' Compensation business in California and Arizona.

In 2004, the Commissioner obtained a court order to forego the comprehensive Proof of Claim process saving the Estate significant cost yet still protecting all recovery rights of the two participating guaranty associations. In 2008, the Liquidator continued to bill, collect, and seek commutation of remaining reinsurance coverage.

The Estate successfully met its goal of completing the commutation of the remaining reinsurance and completion of all of the Liquidator's administrative requirements.

The Estate completed a final distribution in December 2008 and a Declaration of Compliance was filed in February 2009. The estate has now been closed.

Conservation & Liquidation Office

Western Growers Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$13,859,900	$182,100
Recoverable from reinsurers	3,671,900	
Other assets	33,200	
Total assets	17,565,000	182,100

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	205,400	1,700
Claims against policies, before distributions	51,257,000	43,588,700
Less distributions to policyholders	(2,587,500)	(18,101,100)
All other claims		
Total liabilities	48,874,900	25,489,300
Net assets (deficiency)	($31,309,900)	($25,307,200)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$490,600	$3,000
Litigation recoveries		
Salvage and other recoveries	227,900	90,600
Total income	718,500	93,600

Expenses	2007	2008
Loss and claims expenses	(8,167,200)	(6,068,400)
Administrative expenses	378,100	244,300
Total expenses	(7,789,100)	(5,824,100)
Net income (loss)	$8,507,600	$5,917,700

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$4,924,900
Recoveries, net of expenses	13,358,300
Distributions	(18,101,100)
Monetary assets available for distribution	$182,100

Western International Insurance Company
Conservation Order: August 10, 1992
Liquidation Order: September 9, 1992

2008 Report

Western International Insurance Company ("WIIC") was domiciled and licensed in California. The company wrote primarily Property and Casualty insurance. WIIC was conserved on August 10, 1992 and placed into liquidation on September 9, 1992. California Insurance Guarantee Association (CIGA) is the only guaranty association affected. All CIGA claims and CLO in-house claims have already been adjusted. There are only sufficient funds to pay up to policyholder claims class. General Creditor claimants have been advised that there are no available funds to pay claims past the policyholder claims class.

During 2008, the Estate's goal was to resolve all final asset collections, determine final estate liability, and complete a final distribution to claimants. These goals were accomplished.

The Estate's current goal is to distribute newly found assets and file a Declaration of Compliance to close the Estate, both to be implemented in 2009.

Western International Insurance Company

ASSETS AND LIABILITIES
As of December 31, 2007 and 2008

Assets	12/31/2007	12/31/2008
Cash and investments	$10,445,200	$783,000
Recoverable from reinsurers	236,500	
Other assets		
Total assets	10,681,700	783,000

Liabilities	12/31/2007	12/31/2008
Secured claims and accrued expenses	3,100	1,200
Claims against policies, before distributions	59,578,000	59,574,900
Less distributions to policyholders	(17,000,000)	(27,411,700)
All other claims		
Total liabilities	42,581,100	32,164,400
Net assets (deficiency)	($31,899,400)	($31,381,400)

INCOME AND EXPENSES

Income	2007	2008
Investment income	$558,500	$307,100
Litigation recoveries		
Salvage and other recoveries		
Total income	558,500	307,100

Expenses	2007	2008
Loss and claims expenses	(329,400)	(3,100)
Administrative expenses	261,200	(207,800)
Total expenses	(68,200)	(210,900)
Net income (loss)	$626,700	$518,000

CHANGE IN ASSETS AVAILABLE FOR DISTRIBUTION

Beginning monetary assets at takeover	$16,336,000
Recoveries, net of expenses	11,858,700
Distributions	(27,411,700)
Monetary assets available for distribution	$783,000

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:

(a) The names of the persons proceeded against under this article._ _ _ _ _ _ Page 20

(b) Whether such persons have resumed business or have been liquidated or have been mutualized._ Page 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._ _ Pages 4, 10, 11

(2) Annual operating goals and results. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _Pages 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. _ _ _ _ _ _ _ _ Pages 11, 12

(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._ Pages 13-14

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

(6) A list of current year and cumulative distributions by class of creditor for each estate._ _Page 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. P. 21-72

(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._ _ _ _ _ _ _ _ _ _ _ _ _ _ Pages 21-72

(2) The status of the conservation and liquidation process._ _ _ _ _ Pages 21-72

(3) Financial statements, including current and cumulative distributions, comparing current calendar year to prior year._ _ _ _ _ _ _ _ _ _ _ _ Pages 21-72

2008 ANNUAL REPORT

EXECUTIVE OPERATIONS

ADMINISTRATIVE HEARING BUREAU (AHB)

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 the Insurance Code, the Insurance Commissioner is authorized to conduct evidentiary hearings at the AHB on various insurance matters identified below.

The AHB supplies administrative law judges ("ALJ") for many of the hearings provided for by the Insurance Code. In 2008, the AHB employed 4 full-time ALJs, one full time ALJ II supervisor, two legal secretaries, and one office technician. As directed by a particular statute, the ALJs conduct formal or informal hearings under the Administrative Procedure Act ("APA") as well as non-APA hearings provided for by regulation. The ALJs submit proposed decisions to the Commissioner for adoption, modification or rejection. Upon written agreement, the ALJs also will mediate disputes thereby avoiding the necessity of an evidentiary hearing.

The matters heard at the AHB during 2008 include the following:

- prior approval of disputed rate change applications in Proposition 103 lines of insurance (Ins. Code §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 §§11737 and 11753.1),
- allegations of conducting business in a manner hazardous to policyholders, creditors or the public (Ins. Code §§10651.1, 1065.2 and 1756.1(g),
- appeals from the Commissioner's denial of consent for a prohibited person to be licensed (Cal. Code of Regs., title 10, §§2175.1 et seq.) and
- appeals from decisions of CIGA (Ins. Code §1067.10).

In 2008, the AHB opened **50** cases and closed **53** cases.[1] The AHB also presided over several Prior Approval and CIGA cases that were opened in 2007:

Case Type	Opened	Closed
Prior Approval	2	7
Prohibited Persons		0
Workers' Compensation Appeals	44	37
Cease and Desist	4	4
Workers' Comp Rate Disapproval		1

AHB Matters on Writ and Appellate Review

To date, all proposed decisions authored by the ALJs in the AHB and adopted by the Insurance Commissioner have been upheld on writ and appellate review. The status of these cases before the superior and appellate courts in 2008 are as follows:

[1] *The number includes case closures that occurred in 2008 on files that were opened during 2007.*

- **Antelope Valley Newspaper, Inc. (AHB-WCA–04-21)**

Appeal from the superior court's denial of employer's Writ of Administrative Mandamus. The appeal was heard by the 2nd District Court of Appeal. The Commissioner's August 15, 2005, order challenged in this appeal affirmed State Compensation Insurance Fund's decision that home delivery newspaper carriers who had signed Independent Contractor Distribution Agreements with Antelope Valley Newspaper, Inc. were "employees" for whom the appellant employer must provide workers' compensation coverage. The appellate court's decision on this worker status issue is of great importance to the newspaper industry. The court of appeal initially affirmed the Commissioner's decision in an unpublished opinion. Upon a petition from State Fund, the court of appeal rewrote its opinion for publication upholding the Commissioner's decision. (*While the Commissioner has elected not to hear worker status appeals pursuant to Industry-Wide Bulletin No. 2003-5, this appellate court decision provides the newspaper industry and carriers with much needed guidance on the issue of worker status for newspaper carriers.*).

- **Evans Dedicated Systems, Inc._(AHB–WCA-05-33)**

Writ of Administrative Mandamus filed in Los Angeles Superior Court on January 9, 2008. The writ challenges the Commissioner's September 11, 2007, order affirming the Workers' Compensation Insurance Rating Bureau's decision not to use the payroll data proffered by Evans to recalculate the employer's 2003 experience modification. The Commissioner's order also found that no grounds exist to grant Evans equitable relief from the rules of the CA Workers' Compensation Insurance Unit Statistical Reporting Plan and Experience Rating Plan. The parties settled and the writ was dismissed.

- **Hendrickson Trucking (AHB-WCA-05-83)**

Writ of Administrative Mandamus filed in Sacramento Superior Court on February 7, 2007. The matter was set for hearing in March 2008. The writ challenges the Commissioner's October 11, 2006, order upholding the Workers' Compensation Insurance Rating Bureau's decisions to: (1) apply a new experience modification factor to the employer's insurance policy for the period April 1, 2004 to December 1, 2004, and (2) omit the experience of the employer's April 1, 2000 policy in promulgating the employer's December 1, 2004 experience modification. The writ was denied on May 2, 2008.

- **J & R Fernandez**

Writ of Administrative Mandamus transferred to in Los Angeles Superior Court for hearing challenges the Commissioner's order holding that telephone booth installers were independent contractors, even though they lacked construction contractors' licenses, based on a statutory exemption for persons working on public utility projects. Supervision by the phone company that owned all the booths, as well as the ultimate regulatory authority of the PUC, was found to satisfy the intent of the licensing laws. No decision yet on this writ.

- **Pali Camp, dba Pali Mountain Institute (AHB-WCA-04-103)**

  Writ of Administrative Mandamus filed in Los Angeles Superior Court on November 28, 2007, challenged the Commissioner's July 31, 2006, order affirming State Compensation Insurance Fund's decision to assign the employer's payroll to classification 9048 "Camps – recreational or educational – all operations --- including Clerical Office Employees at camp locations". The writ was denied.

OFFICE OF CIVIL RIGHTS (OCR) (formerly Equal Employment Opportunity Office)

The OCR's objective 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. This year, the OCR has implemented a policy of handling all complaints internally, with the few exceptions where a conflict of interest may exist, thereby directly and drastically cutting operating expenses. To this end, the OCR has moved to a more discrete location that will encourage employees to report possible violations of the Department's policy to CDI first. This will reduce the number of complaints initially reported to outside State and federal agencies. The OCR staff promotes an open door policy so CDI employees can contact the OCR about any issue at any time.

American's with Disabilities Act (ADA) Compliance

In addition, the OCR Office 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 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 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, the OCR is currently updating the Department's ADA plan. We are asking each bureau, through survey, to identify any barriers to the disabled within their programs, policies, procedures and locations. Although the updated ADA plan is not complete, we do not anticipate any major barriers to be identified, as staff throughout CDI has diligently worked 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 EEO Office has two permanent positions- the Equal Employment Opportunity (EEO) Officer, who is also CDI's ADA Coordinator, and the EEO Investigator. These two positions will allow OCR staff to conduct internal investigations and cut costs on contracts to outside investigators.

The State Personnel Board is now requiring all state agency EEO Officers and EEO investigators to complete a block of EEO training courses. At CDI, the OCR staff have begun these classes and plans to complete the series in the 2009-2010 fiscal year.

ETHICS & OPERATIONAL COMPLIANCE OFFICE (EOCO)

The Ethics and Operational Compliance Office (EOCO) provides management of the Department with independent, objective, accurate and timely information necessary to make policy decisions. The EOCO assists management in their efforts to increase operational and program efficiency and effectiveness by providing them with analysis, appraisals, recommendations, and technical assistance.

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

The EOCO is composed of three distinct functions with six staff members reporting to the Special Assistant to the Commissioner:

- Internal Audits Unit
- Curriculum Compliance Audits 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 and for the Conservation and Liquidation Office 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 EOCO 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.

Curriculum Compliance Audits Unit

The Curriculum Compliance Audits Unit conducts reviews of insurance education providers' pre-licensing and continuing education courses to ensure the curriculum and provider operations adhere to California's Insurance Code and Code of Regulations. The audit findings are intended for use by the Licensing Services Division to assist them in reviewing the quality of education to ensure adequate training for the licensing and continuing education requirements of insurance agents and brokers.

The auditors also report quarterly to the Curriculum Board on the progress of the audit function, audit production plans and common audit findings. Any significant fraudulent or criminal activity discovered during an audit would be referred to the Enforcement Branch for further review and investigation.

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.

INFORMATION SECURITY OFFICE (ISO)

The Information Security Office (ISO) provides oversight and compliance review to ensure that the Department's data is protected against unauthorized use. Information security means the protection of information and information systems, equipment, and people from a wide spectrum of threats and risks. Implementing 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) is critical to ensure business continuity and protection against unauthorized access, use, disclosure, disruption, modification, or destruction.

Each agency must provide for the proper use and protection of its information assets. Accordingly, each agency must perform the following:

1. Assign management responsibilities for information technology risk management, including the appointment of an Information Security Officer (SAM Section 5315).

2. Provide for the integrity and security of automated and paper information, produced or used in the course of agency operations (SAM Sections 5310 through 5350).

3. Provide for the security of information technology facilities, software, and equipment utilized for automated information processing (SAM Section 5330).

4. Establish and maintain an information technology risk management program, including a risk analysis process (SAM Section 5305).

5. Prepare and maintain an agency Disaster Recovery Plan (SAM Section 5355).

6. Maintain a security and ongoing privacy program including an annual training component for all employees and contractors (Government Code 11019.9 and Civil Code 1798 et seq).

7. Comply with the state audit requirements relating to the integrity of information assets (SAM Section 20000 et seq).

8. Comply with state reporting requirements (SAM Section 5360).

Each state data center must carry out these responsibilities for those automated files, databases, and computer systems for which it has ownership responsibility (SAM Sections 5320 and 5355.3).

THE OFFICE OF THE OMBUDSMAN

The Office of the Ombudsman responds to inquiries and requests for assistance from consumers, agents and brokers, and elected officials inquiring on behalf of constituents. When consumers request it, Ombudsman officers conduct second reviews of cases handled elsewhere in the Department to assure that all available consumer protections have been considered. Inquiries are received by mail and telephone and, increasingly, by email. In 2008, Ombudsman staff responded to over 1300 inquiries, about half of them referrals from legislators and the governor. The unit also coordinates the Commissioner's appointments to 9 boards and committees and conducts other special projects as requested by Executive Staff.

CALIFORNIA ORGANIZED INVESTMENT NETWORK

The mission of the California Organized Investment Network (COIN) 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. COIN carries out this mission through two distinct programs.

1. **The COIN Program** – COIN facilitates and encourages the insurance industry to maximize their voluntary investments benefiting California's low-to-moderate income people and communities.
2. **The California Community Development Financial Institution (CDFI) Certification and Tax Credit Program** – As provided under California law, COIN certifies tax credits to California taxpayers making investments meeting certain specification in financial institutions that COIN has determined meet California's requirements to be designated as a CDFI.

1. The COIN Program

Established in 1997, the COIN Program is a first-in-the-nation collaborative effort among the insurance industry, the state department regulating the industry and the various stakeholders involved with community development investment in traditionally underserved communities. COIN serves as a liaison between insurers and community organizations, as a facilitator, and as a clearinghouse of California community development investment information. By working with nonprofit organizations, community economic development agencies, affordable housing groups, and local governments, COIN seeks to maximize insurer awareness of the widest possible choice of community development investment opportunities.

The rewards of increased industry community development investing are economically healthy communities where the insurers who have made a difference will have established profitable partnerships and earned significant good will. These translate directly into new, profitable business opportunities, while achieving significant social benefit for underserved communities.

One way COIN assists community development organizations that are seeking insurer investment capital is working with them to develop COIN Investment Opportunity Bulletins. In order to maximize insurer awareness of these investment choices, COIN seeks out various opportunities for disseminating the bulletins, including mailing and emailing them to insurers, making them available at insurance industry trade association meetings, and posting them on the COIN Web site: http://www.insurance.ca.gov/0250-industry/0700-coin/

Another way COIN carries out its roles as liaison and facilitator is by promoting the COIN Program at various events throughout the year.

2008 COIN Program Highlights

2009 Data Call

Pursuant to AB 925 (Chapter 456/2006, Ridley-Thomas), insurers admitted to do business in California are required to report the community development investments they made in California during the 2007 and 2008 calendar years to the Department of Insurance by May 31, 2009. To increase participation in the 2009 COIN Data Call; Insurance Commissioner Poizner addressed a letter to 1334 admitted insurer CEO/Presidents to communicate with them about the upcoming Data Call. On April 15, 2009 links to instructions and reporting forms for the 2007 and 2008 investments were provided to NAIC Annual Statement contacts via email.

Data Call Analysis

In 2008 COIN analyzed 2005 and 2006 Data Call information and made it available online in our searchable database. COIN also included a new field for investments which were considered to be High Impact.

- *COIN Qualified Investments* - In 2008 COIN updated the searchable database for 1733 investments totaling $5.9 billion which met the definitions in the Data Call for California community development investments. This is an increase of $2.7 billion over the previous two-year period. Up to date, $14 billion in California community development investments have been made and reported (calendar years 97-08), with $5.8 billion being reported just for calendar years (CYs) 2005 and 2006.
- *High Impact Investments* - Within the arena of community development investing, there are some investments that merit additional recognition. These community development investments typically involve a non-profit or community development organization and/or meet a special or unmet capital need for low-to-moderate income families. Insurers made 325 high impact investments totaling $466 million during CY 2005 and 2006.

2. The California CDFI Certification and Tax Credit Program.

COIN reviews applications and designates qualifying applicants as California CDFIs. To qualify for certification, CDFIs must be private financial institutions - such as community development banks, loan funds, credit unions, micro enterprise funds, corporation-based lenders, or venture funds - that are specifically dedicated to and whose core purpose is to provide financial products and services to people and communities underserved by traditional financial markets.

COIN also certifies the tax credits under this program. The tax credits are not restricted to insurers. Any California taxpayer of Personal Income Tax, Bank and Corporation Tax, or Insurance Gross Premium Tax is eligible to receive tax credits for qualifying investments in certified California CDFIs. The tax credit amount is 20% of the investment amount.

COIN reviews applications for tax credits submitted by the CDFIs on behalf of their investors. To qualify, investments must be zero interest deposits or loans, equity investments, or equity-like debt instruments of $50,000 or more invested for a minimum of 60 months in California certified CDFIs. After determining that the investments qualify, COIN provides the taxpayers with tax credit certificates and annually reports the year's tax credits to the Franchise Tax Board and the Board of Equalization.

2008 California CDFI Tax Credit Program Highlights

- Certified 18 investments from 6 investors totaling $6.425 million.
- In 2008, the Department sponsored AB 3054 to modify the language of CIC 1182 to include "insured Credit Unions". Currently small domestic P&C companies are not authorized to make discretionary investments under current law. Current law constrains these insurers from making these insured and safe deposits in community development credit unions that make high impact investments that help California low income families and communities.
- In 2008, the Department supported AB 1910 to amend Section 926.2 and to add Section 926.3 to the Insurance Code, relating to insurer investments. AB1910 was introduced by Assembly Insurance Committee Chair Joe Coto to increase community development investments in California. AB 1910 would have extended the sunset date on Section 926.2 to January 1, 2015. This bill also required insurers to develop and file with the commissioner a "Community Development Investment" policy which expresses the insurer's goal for community development investing in the current and following calendar years. AB 1910 was passed by the Senate and Assembly although vetoed by the Governor, and since has been re-introduced as AB 41 on December 31, 2008.

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ADMINISTRATION & LICENSING SERVICES BRANCH

ADMINISTRATION & 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) Bureau provides custom software development including the Integrated Database, the Fraud Integrated Database system, internet/intranet development, custom interfaces between applications and testing services. ADAM monitors and maintains the Oracle Internet Application Server, commonly referred to as the 'middle tier', and works with data administrators at the Department of Technology Services where CDI's department data is stored.
- **Project Coordination and Administrative Support Bureau** (PCAS) includes a Project Management Office (PMO) and an Administrative Support Office (ASO). The PMO provides project management methodology and project management for information technology (IT) projects and is responsible for Control Agency programs such as the Software Management Program and the Desktop and Mobile Computing Policy. The ASO facilitates information technology related purchases and tracks requests for technology services.
- **The Web Services Bureau** (WS) is responsible for leading CDI's ongoing effort to institutionalize website accessibility, usability, and find-ability 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 Content Contributors and Content Managers responsible for the static content in the internet and intranet websites. As of January 2009, the WS Bureau is now offering video services for the Department.

Major Operational Projects:

- **Paperless Workflow Project (PWP)** – On April 1, 2008, the CDI obtained approval of the Paperless Workflow Project Feasibility Study Report. In FY 2008-09 and 2009-10, the CDI obtained Legislative approval for funding of the initial and second year of PWP implementation activities. The project is intended to provide all CDI stakeholders with the most cost-efficient and "green" methods of transacting services. The CDI will continue working with the Legislature and the Department of Finance in securing the remaining funding that is necessary to fully implement the PWP by FY 2011-12.
- **Server Virtualization Effort –** The IT is continuing its efforts to consolidate CDI's server environment through 2009. The plan is to virtualize the remaining 44 servers that reside in our San Francisco and Los Angeles sites down to seven. Not only will CDI continue to save on maintenance of server hardware, it will continue to meet the Commissioners' green initiative. This solution has helped CDI in its green efforts with the reduction of electrical usage and carbon emissions
- **Online Assistance System for Insurer Submittals –** Complimentary to the Paperless effort, CDI began efforts in late 2008 to allow the online submission of various insurer applications and financial statements through CDI's website. Plans are to continue to implement these application submittals through 2009.

Key IT Accomplishments in 2008:

Legislatively Mandated Changes to CDI's Licensing Systems -- Major enhancements were made to CDI's Licensing system - COSMOS and all internet and intranet systems dealing with licensing, license renewals, and education. The life license was split into Life Only and Accident and Health qualifications and fees were reduced for Surplus Lines licenses.

Company Financial Statements on the Internet -- Company Financial information was added to the newly revised Company Profile web page for consumers. This interface makes annual/quarterly and other financial documents for domestic insurers and eligible surplus lines companies available to the public in PDF format on the department's public web site. Additionally, Public California Supplements not filed with the NAIC, and the public synopsis of the Underwritten Title Companies (UTC) statement has also been included.

New Title Marketing Representative (new certificate of registration) – Due to new legislation, the Department now regulates those representatives that market, offer, solicit, negotiate, or sell title insurance. This new certificate of registration was added to CDI's online licensing application system and the online business entity endorsement and termination service to allow employers (e.g. title insurers and underwritten title companies) to submit employment and training notifications. The online renewals will be launched in 2010. This is the first certificate that is only available online.

Rate Regulation's Web-based Prior Approval Rate Application – The IT developed a new intranet prior approval rate application for rate regulation processing activities. These process enhancements include the ability to report rate changes statistics for rate changes requested by insurers in a more user-friendly format and/or the public outlining the filings received, and type.

Server Virtualization (Sacramento) -- Fifty-five servers were consolidated to six via virtualization software and hardware. This was done at the Sacramento site with little downtime and improved server and application performance. This solution has helped CDI in its green efforts with the reduction of electrical usage and carbon emissions.

Intranet Redesign Project -- The CDI's intranet is a vital communications tool for fulfilling the CDI's regulatory objectives. This project improved the intranet and efficiency of the CDI to make the information it contains more accurate, timely, relevant, and complete so that CDI can better meet the needs and expectations of staff and help them better protect and serve constituents. Training sessions were administered to all content contributors and managers as well as several new concepts were presented on the new Intranet (event calendar, training videos, etc).

State-of-the-Art Web Presence Project: Phase I -- The ITD has implemented the first steps in creating a competitive web presence that includes real time interaction and information sharing between the Department and consumers of California. The initial phase of the project resulted in an infrastructure to provide web solutions such as streaming video and live web casts of press conferences, real-time live chats between California consumers and CDI experts, "Town Hall" question and answer sessions, and surveys.

New Electronic Funds Transfer (EFT) features Secured File Transfer Protocol (SFTP) – The CDI has become the first agency within the current 11 agency members for the state of California to develop and implement Secured File Transfer Protocol (SFTP) for its Electronic Funds Transfer (EFT) system. CDI currently transfers $2.4 billion dollars annually using EFT for the 12,000 transactions received from 1,500 insurers.

Web Access to Rate and Form Filings (WARFF) -- A web-based application was developed in order for the public to access rate and form filings via the internet. Constituents can search for Rate Filings on the public web site and retrieve a scanned copy of the original Rate Filing document that is part of Rate Regulations document management system.

Human Resources Intranet P2 Tracking System -- A web-based system was created that allows Human Resources (HR) Management Division the ability to track the progress and status of the department's P2 packages submitted by the branches. This gives HR the ability to track the progress and status of the hiring package through the entire review and approval process.

Enterprise Information Portal Project (EIP) – Phase II -- Phase II of the EIP was released in December that allows for more key performance indicators and alerts for business areas. This includes centralized budget reports, human resource vacancy reports and new business area data such as California Organized Investment Network, Rate Filing data, Boards and Commissions data and improved legal information on company and producer data.

Recognition from the Consumer Federation of America -- The Consumer Federation of America recognized CDI's website as excellent in the auto and homeowner insurance information that CDI provides to consumers. They found the information presented on the website to be complete, up to date, and easy for consumers to use. The study reported that consumers accessing these websites could easily find current price, complaint and solvency information and could find key information on how to get the best claim settlements as well. The web pages that were recognized include the following:

- The Internet Request for Assistance
- Homeowners/Auto Premium Comparison Surveys
- Search for Enforcement Action Reports
- Search for Market Conduct Examination Reports
- Search for License/Broker Information
- Consumer Complaint Data

National Association of Chief Information Officers (NASCIO) -- The National Association of Chief Information Officers selected 30 state IT initiatives in 10 categories as finalists for the 2008 Recognition Awards for Outstanding Achievement in the Field of Information Technology in State Government. NASCIO named CDI's Telecommunications Infrastructure Replacement Project as a finalist for outstanding achievement in information communication technology innovations. The Department's Telecommunications Infrastructure Replacement Project was completed in 2008 and involved the replacement of a nearly 20-year old system with state-of-the-art Voice over Internet Protocol (VoIP) infrastructure. Included in the replacement was the successful installation of 1500 handsets, 150 soft phones, and several call center applications. This transition has enabled the Department to better serve California consumers, in addition to saving $80,000 per year in long distance charges and communication lines.

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 Business Process Bureau.

- **Producer Licensing Bureau (PLB)** is primarily responsible for issuing, maintaining and updating records of all insurance producer licenses; preparing and administering written qualifying insurance examinations; and the review and approval of education courses submitted by insurance companies, educational institutions, and others.
- **Licensing Background Bureau (LBB)** is responsible for obtaining information and documentary evidence regarding criminal convictions and other adverse actions in the backgrounds of insurance producers, licensing applicants, and organizations seeking authority to transact insurance in California. LBB analyzes the evidence and recommends a course of action against the licensee/applicant.
- **Licensing Compliance and Business Process Bureau's** (LCB) assists the Enforcement Branch's Investigation Division with the review and analysis of case files received from the Investigation Division's Complaint Intake Unit. LCB consists of three units: the Licensing Compliance Unit, the Business Process Reengineering Unit and the Surplus Line Filing Unit.

Key LSD Accomplishments in 2008:

PLB successfully implemented new legislation (AB 720, statutes of 2007) regarding the sale of life, accident and health insurance, which took effect on January 1, 2008. The bill made significant changes to the life license qualifications, including changes to the prelicensing and continuing education (CE) requirements contained in Section 1749 et seq. of the California Insurance Code (CIC). The primary focus of the bill was to establish two new license types, a life-only agent license and an accident and health agent license. Consequently, applicants can now apply for a life-only agent license or an accident and health agent license or for both a life-only and accident and health agent license.

The creation of these two license types, with the accompanying prelicensing, examination and CE requirements resulted in California being consistent with other states' licensing requirements to sell these types of insurance.

New Surplus Line Broker license requirements – The PLB successfully implemented new legislation (AB 1639, statutes of 2007) to change California's surplus line broker licensing laws for streamlining the licensing process and to become uniform and reciprocal with other states in regards to non-resident licensing of surplus line brokers. This legislation, in part, made significant changes to the surplus line broker licensing requirements and fees contained in sections 1765 and 1765.3 of the CIC.

Revised Surplus Line Broker Fees – On June 13, 2008, PLB implemented AB 1699 (statutes of 2008), an urgency bill, which amended sections 1750, 1765, and 1765.2 of the CIC. This law made further adjustments to the surplus line brokers' fees, which had been reduced from $1,200 to $700 under AB 1639. Rather than the fee for all surplus line brokers at $700, the fees were adjusted so that organizations and individuals who transact on their own behalf are to pay $1,000 per the two-year license term while individuals only transacting on behalf of an organization are to pay $500.

New Limited Lines Automobile Insurance Agent License – The PLB successfully implemented new legislation (AB 797, statutes of 2007) which added Section 1625.55 to the CIC that took effect on January 1, 2008. This bill created a limited lines automobile insurance agent license that allows individuals and organizations to be licensed solely for transacting automobile insurance. Additionally, this bill amended Section 1749.1 of the CIC to allow up to 25 percent of an agent or broker's CE requirement to be from courses in business management practices.

Reduced Processing Backlogs - In recent years, CDI developed several online services available to insurance agents, brokers and applicants. These services provide for quicker license issuance, reduction of processing errors, immediate update of license records, and lower operating costs for insurance companies and agencies. Use of these services also results in timelier fund deposits from the online transactions, as the fees are paid by credit card. The increased use of these online licensing services is consistent with the Commissioner's strategic goal to have 100 percent paperless interaction with agents, brokers and insurance companies by 2010.

Key LSD Statistics -The chart below compares key workload statistics between calendar years 2007 and 2008.

STATISTIC	TOTAL – CY 2007	TOTAL – CY 2008	PERCENTAGE CHANGE
License Applications Received	74,443	77,698	+ 4%
License Examinations Scheduled	62,081	64,700	+ 4%
New Licenses Issued	53,100	56,035	+ 6%
Licenses Renewed	124,197	104,319	-16%
Insurance Company Appointments and Terminations	511,398	699,300	+37%
Bonds Processed	8,524	7,510	- 12%
Telephone Calls Handled by Producer Licensing Staff	234,496	123,457	N/A*

**During 2008, CDI switched to a new telephony system that provides reports, which track the number of producer licensing hotline calls answered by the customer service agents. The reports available from the previous telephone system did not distinguish between those calls answered by the customer service agents from the calls that were processed through the interactive voice response system. Consequently, any comparison of telephone calls handled between 2007 and 2008 is not relevant.*

License Information required by the California Insurance Code - AB 720, statutes of 2007 added Section 1707.7 to the CIC to require annual statistics on several agent and broker licenses to be included in the next five annual reports of CDI. The following statistical information is included in this report to meet this mandate.

(A) During 2008, the total number of applications received for the following licenses were as follows:

- Fire and Casualty Broker-Agent -17,741
- Personal Lines Broker-Agent - 2,901
- Limited Lines Automobile-Only Agent - 670
- Life-Only Agent - 50,289*
- Accident and Health Agent - 37,144*

**These totals include those individuals who applied for both the Life-Only Agent and Accident and Health Agent licenses on the same application and therefore their one application is reflected in both categories.*

(B) During 2008, the total number of licenses issued for the following licenses were as follows:

- Fire and Casualty Broker-Agent - 11,756
- Personal Lines Broker-Agent - 2,767
- Limited Lines Automobile-Only Agent - 278
- Life-Only Agent - 32,543*
- Accident and Health Agent - 27,136*

**These totals include those individuals who were issued licenses for both the Life-Only Agent and Accident and Health Agent licenses on the same date and therefore are counted in both categories.*

(C) The total number of licensees with both a Life-Only Agent license and an Accident and Health Agent license on December 31, 2008 was 205,379.

LICENSING BACKGROUND BUREAU (LBB)

Case Work Statistics for 2008

The chart below compares LBB's key workload statistics between calendar years 2007 and 2008.

STATISTIC	TOTAL – CY 2007	TOTAL – CY 2008	PERCENTAGE CHANGE
Background Reviews Completed	3,638	3,834	+ 5%
Cases Referred to Legal Division for Formal Disciplinary Action	324	251	(23) %*
Cases Concluded Under the Alternative Resolution Program	757	765	+ 1%

**Note: The 23 percent reduction in cases referred to the Legal Division for Formal Disciplinary Action is due to a higher number of cases resolved by warning letter or informal action. In addition, during 2008, LBB denied 364 applications, issued 222 restricted licenses and revoked 161 licenses.*

LBB Casework is derived primarily from the following 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 history 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 and will not issue the license until the CORI results are received from both DOJ and FBI.
- CDI's Legal Branch requires background reviews of persons serving as an officer or controlling person of an insurance company doing or proposing to do business in this state.
- The National Association of Insurance Commissioners (NAIC) provides daily reports on out-of-state administrative actions through its NAIC Regulatory Information Retrieval System (RIRS).

Alternative Resolution Program – The 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.

Certain criminal convictions and previous regulatory actions have a direct bearing on the qualification of persons applying for licenses. Violent crimes and serious economic crimes, such as assault, rape, forgery, embezzlement, and theft, are of particular concern; and, are grounds for the Commissioner to deny or revoke a license. The background information collected by LBB is used to evaluate an applicant's background and, when appropriate, to present as evidence in legal proceedings to deny or revoke a license.

In 2008, LBB enhanced its internal case tracking system to better account for the time spent tracking cases sent for legal review under the Alternative Resolution Program. A new feature was added to allow LBB analysts to track the time spent on the case while the file is pending Alternative Resolution Program settlement. Further, these enhancements added more features for LBB to track their case activities on-line through CDI's enterprise information database, and created more options for paperless tracking of the case activities on each case.

LICENSING COMPLIANCE AND BUSINESS PROCESS BUREAU (LCB)

During 2008, LCB reviewed minor violations of the California Insurance Code (CIC) by the industry, identified and implemented changes to the processes of LSD and assisted in the processing of applications of non-admitted insurers applying for inclusion on the CDI's List of Eligible Surplus Lines Insurers (LESLI). LCB consists of the following three units:

Licensing Compliance Unit -- The Licensing Compliance Unit is responsible for reviewing minor violations of the CIC committed by agents and brokers with authority to transact insurance in California. Suspected minor violations are referred to the unit from CDI's Investigation Division. These referrals include the use of unapproved fictitious names, improper or no license, improper or misleading advertising and other minor violations. The Unit's primary goal is to bring those in violation into compliance with the CIC. In cases in which the subject will not cooperate, or in cases of repeated non-compliance, the unit will either refer the case back to the Investigation Division for further review or initiate formal legal action through CDI's Alternative Resolution program.

Statistics -- The chart below shows the licensing compliance cases completed in calendar years 2007 and 2008.

STATISTIC	CY 2007	CY 2008	PERCENTAGE CHANGE
Issued Warning Letters- Brought into Compliance	117	94	(20)%
No violation found	51	35	(31)%
Referred to Investigation Division	10	27	+170%
Referred to Legal Division	5	10	100%
TOTAL	183	166	(9)%

Business Process Reengineering Unit - The Business Process Reengineering Unit identifies and implements changes to LSD's processes to improve the efficiency and effectiveness of the division's operations, makes recommendations to management on procedures, policies and program alternatives, and works closely with the Information Technology Division on various projects.

Surplus Line Filing Unit -The Surplus Line Filing Unit assists in processing the applications of non-admitted insurers applying to be added to the LESLI list. This unit coordinates with the CDI's Legal and Financial Analysis divisions and the Surplus Line Association of California.

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; participates in the presentation of personnel matters before the State Personnel Board (SPB), the Department of Personnel Administration (DPA), or other official bodies; reviews proposed personnel actions for conformity with regulations, classification and pay standards, and good personnel practices.
- **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 processing of all payroll.
- **The Exams, Recruitment, Selection and Training Unit** administers the Civil Service Exam process; certification and eligibility lists; coordinates all outreach recruitment and job fair activities; investigates merit issues; complaints, exam appeals, and all request for withholds; coordinates training and the upward mobility program for Department employees; facilitates the Department's annual award and recognition programs.
- **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 2008:

On-Line Application Process for Fraud Investigator Exams — In ongoing efforts to improve the Department's investigator recruitment activities while maximizing processing technologies, the HRMD is working with the ITD in developing an "on-line filing" of applications, MQing, exam scheduling via the internet. The online filing component has been completed and programmed by the State Personnel Board and is in the process of being implemented. The Department is also currently working with the HRMD Modernization Project Team in the development of an online statewide investigator exam for all state agencies. It is anticipated to be available in August 2009.

Recruitment and Marketing Efforts for Fraud Investigator Examination — The HRMD worked with the ITD to revise the Department's internet homepage to provide comprehensive links to the Fraud Division site. There has also been an expansion of job advertisement methods by developing a Fraud Division MySpace page that is currently being evaluated for effectiveness in capturing an additional candidate pool. The HRMD will continue surveying employment candidate pools and making the necessary adjustments to further improve the Department's recruiting and marketing efforts.

Intranet Redesign Project for HRMD — The HRMD developed an intranet webpage providing Department employees with essential human resources information including related links, and HRMD forms for on-line access.

Developed Robust Training Program Model for CDI Supervisors and Managers — The HRMD designed a robust training program for CDI supervisory and management staff. The subject training includes leadership academies; developing training components and course content through the use of needs assessments; and analysis of data collected from designated departmental representatives.

CDI Leave Coordination Consolidation — For purposes of improving employee services, the HRMD consolidated all activities relating to the processing of leaves of absence and maintenance of pay benefits and health insurance for employees. The subject consolidation involves the following types of leave transactions intended to improve employee services:

- Workers' Compensation Leave and Benefits
- Family Medical Leave Act (FMLA)
- California Family Rights Act (CFRA)
- State Disability Insurance (SDI) and Paid Family Leave (PFL) benefits
- Non-industrial Disability Insurance (NDI) benefits
- Employees accumulated sick leave, vacation, and annual leave usage
- Pregnancy Disability Leave Act
- Catastrophic Leave Program
- Transfer of Leave Credits from Family Members Program

Streamlined internal processes in the Personnel Transactions Unit — The HRMD streamlined its internal personnel transaction units work processing resulting in a more cost-effective and efficient operation benefiting employees and the organization.

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 $2.16 billion in tax revenue was collected for Fiscal Year 2007-08 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) 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. The BRMB is also responsible for administering the Administrative Systems Unit that oversees CDI's Time Activity Reporting System (TARS), providing TARS training and technical assistance to all CDI staff, providing technical financial support to users of various fiscal systems including CALSTARS, establishing of new program cost accounts, updating of cost allocation plan, and developing 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 the Financial Management Division's (FMD) 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 2007, the Accounting Services Bureau processed a total of 3,493 tax returns as follows:

INSURANCE TYPE	NUMBER OF ANNUAL TAX RETURNS	TAX RATE	LAW REFERENCE
Surplus Line	1,529	3%	California Insurance Code 1775.5
Property & Casualty	886	2.35%	California Revenue & Taxation Code 12202
Ocean Marine	572	5%	California Revenue & Taxation Code 12101
Life	470	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	**3,493**		

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

2003..... $1,949,975,000
2004.....2,056,524,000
2005.....2,124,097,000
2006.....2,167,242,000
2007.....2,163,422,000 *

* Collection as of March 31, 2009

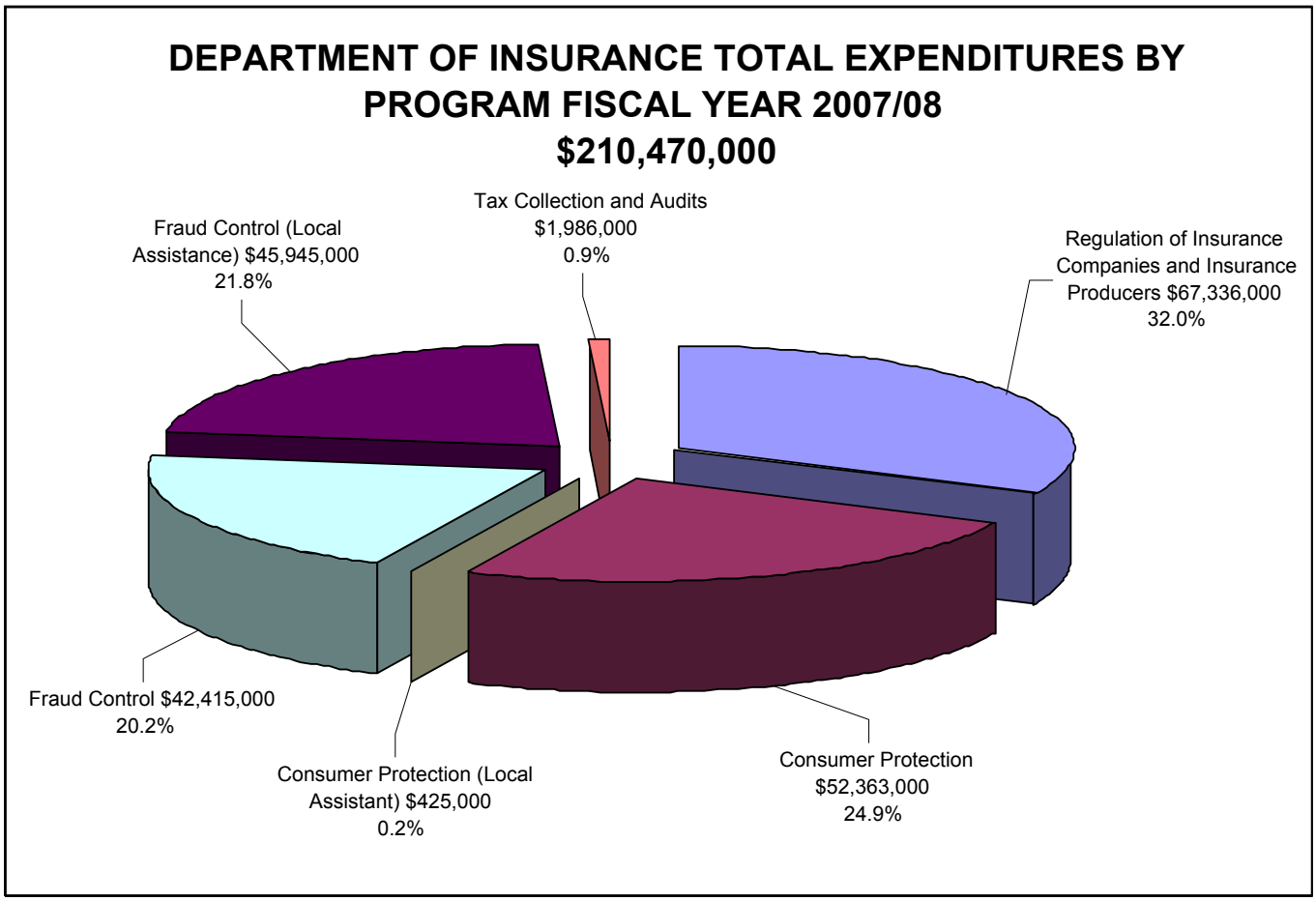
CDI BUDGET - For FY 2007-08, the CDI's budget consists of the following four programs:

- **Regulation of Insurance Companies and Insurance Producers (Program 10)** - $67,336,000 of the FY 2007-08 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)** - $52,363,000 was spent for state operations and $425,000 for local assistance in FY 2007-08. 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.

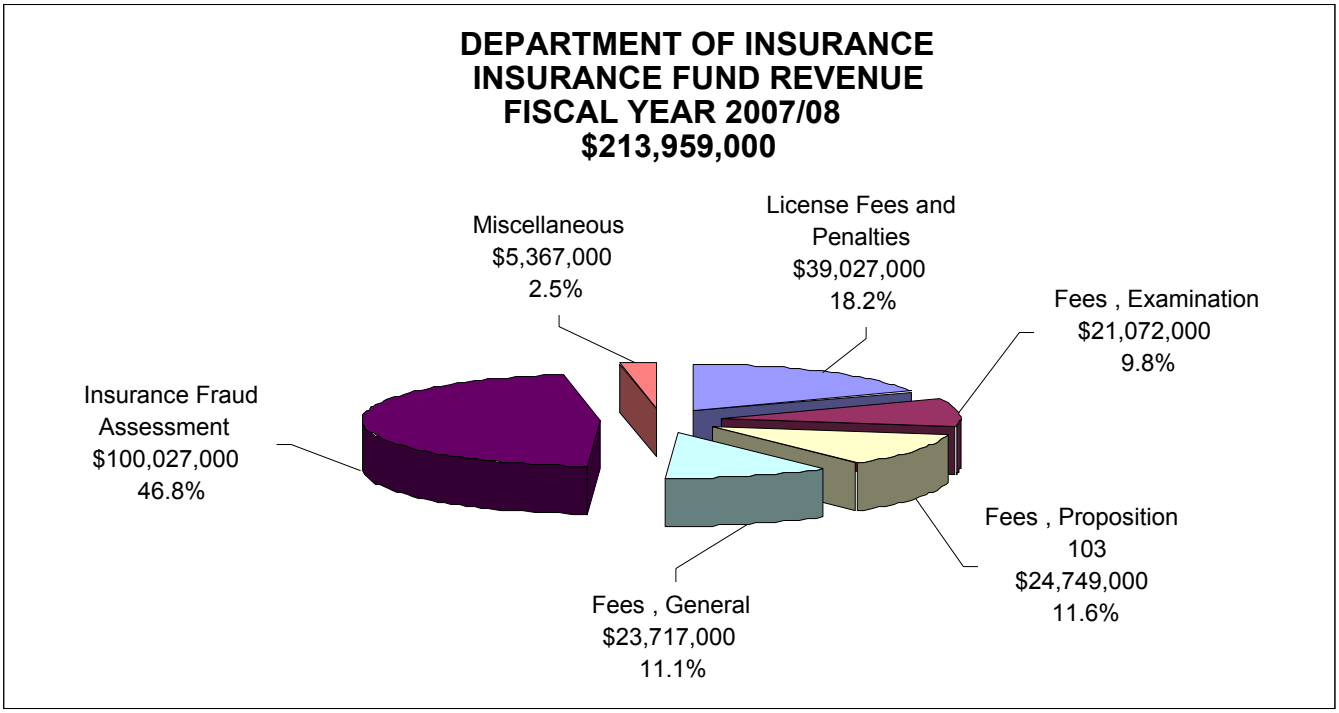
- **Fraud Control (Program 20)** - $42,415,000 was spent for state operations and $45,945,000 for local assistance in FY 2007-08. The program protects the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and reduces the overall incidence 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)** - $1,986,000 was spent in FY 2007-08 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 expenditures by program for fiscal year 2007-2008.

Regulation of Insurance Companies and Insurance Producers	$67,336,000 (32.0%)
Consumer Protection	$52,363,000 (24.9%)
Fraud Control (Local Assistance)	$45,945,000 (21.8%)
Fraud Control	$42,415,000 (20.2%)
Tax Collection and Audits	$1,986,000 (0.9%)
Consumer Protection (Local Assistant)	$425,000 (0.2%)
Total	$210,470,000



The pie graph above shows the Department of Insurance fund revenue for fiscal year 2007-2008 and is described on the table below.

CDI REVENUES

In Fiscal Year 2007-08, the CDI generated $214 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	$39,027,000	18.2%
Fees, Examination	$21,072,000	9.8%
Fees, Proposition 103	$24,749,000	11.6%
Fees, General	$23,717,000	11.1%
Insurance Fraud Assessment	$100,027,000	46.8%
Miscellaneous	$5,367,000	2.5%
TOTAL INSURANCE FUND REVENUE	**$213,959,000**	**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 $1.80 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.
    5. Life and Annuity – An annual assessment of $1.00 per policy assessment levied on life and annuity insurers.

CDI DISBURSEMENTS

The chart below illustrates the CDI's disbursements by category for FY 2007-08:

Category	Disbursement
Personal Services	$108,641,000
Operating Expenses and Equipment	$55,459,000
Local Assistance	$46,370,000
TOTAL DISTRIBUTED	**$210,470,000**

- **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 used 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.

2008 ANNUAL REPORT

COMMUNICATIONS & 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 role 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 also 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 and press events. Importantly, the Communications staff key responsibility is to deliver information which is vital in representing the message of the Insurance Commissioner and the Department.

2008 ANNUAL REPORT

COMMUNITY RELATIONS BRANCH

COMMUNITY RELATIONS BRANCH

The Community Relations Branch (CRB) works to connect the California Department of Insurance (CDI) with California consumers and communities. 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 agencies. 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 California Department of Insurance.

CRB is charged with a number of mandates by which CDI services are delivered to California's insurance consumers and communities. CRB delivers services through two offices, CRB branch office, & the Consumer Education and Outreach Bureau (CEOB). The Branch offices deliver programs under specific mandates, requirements, and goals. CRB's 2008 activities, broken down by office/program, are represented below:

COMMUNITY RELATIONS BRANCH OFFICE

For 2008 the CRB branch office led the Consumer Advisory Task Force, the CDI Green Initiative and administered the outreach budget and service delivery contracts for the California Low Cost Automobile Insurance Program.

Consumer Advisory Task Force

The Consumer Advisory Task Force was created to establish and maintain an effective line of communication between CDI and California's consumer advocates. The task force was originally formed in December 2007 and met a number of times in 2008. Task Force meetings facilitated direct communication with CDI's Executive Officers and with individual functions such as the Legislative and Legal offices.

CDI Green Initiative

The Commissioner is committed to reducing the department's carbon footprint through the implementation of immediate and long-term green practices. CRB was tasked with coordination of responsibilities for the Green Initiative. CRB worked, in coordination with all bureaus, to assess current performance and establish systems to manage the department's evolution to green operations.

California Low Cost Automobile Insurance - Program

Please see the California Low Cost Automobile (CLCA) Insurance Annual Report listed at the end of the CEOB section for a thorough overview of CLCA activities for 2008.

CONSUMER EDUCATION AND OUTREACH BUREAU

The Consumer Education and Outreach Bureau (CEOB) was created 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.

Comprised of insurance experts, CEOB has enhanced the Department's efforts to educate consumers and find new ways for Californians to learn about the ever-changing insurance industry and products. CEOB handles a variety of events throughout the state often in partnership with civic, community, educational, law enforcement organizations, and other state agencies.

CEOB is involved in the development of Insurance Recovery Forums (town halls meetings) and coordinating hearings for the Insurance Commissioner. When necessary, CEOB assists in disaster outreach events following major disasters in the state.

CEOB also provides presentations on a variety of insurance issues; conducts workshops, health forums, seminars, and participates on educational panels.

In 2008, CEOB distributed over 265,000 insurance related informational guides and coordinated or participated in more than 267 outreach events throughout the State as follows:

Senior Events	61
Youth/Parent/Faculty	17
Planning Meetings	18
Staff Training/Presentations	77
Homeowner/Resident	03
Disaster (Wildfire)	05
Insurance Recovery Forums	01
Consumer Oriented	82
Total Events & Meetings	**267**

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.

By becoming more informed on insurance issues, consumers are better able to purchase insurance products that meet their needs, or evaluate existing insurance products that have been purchased to better protect themselves from unfair insurance practices.

CEOB Objectives and Goals

The objective goals of the Commissioner's Strategic Vision for CRB were to promote CLCA as well as to assist in increasing consumer education by developing and offering web-based videos and other information at the CDI website. The success metric, which has a completion date of September 2009 is the deployment of functionality that allows consumers to (1) "attend on demand" (streaming video) hearings and other CDI meetings and events without the need to travel; (2) interact with Department experts on specified subjects via "live chat" and (3) survey stakeholders to identify and prioritize which web-based activities will better serve their needs.

REPORT TO THE LEGISLATURE ON THE CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM

The California Low Cost Automobile pilot program ("CLCA") was enacted in 1999 to create an affordable insurance option for low-income, good drivers in Los Angeles County and the City and County of San Francisco to comply with California's financial responsibility laws (SB 171, Escutia and SB 527, Speier).

Legislative modification and enhancement of the program occurred in 2002, with the enactment of Statutes 2002, Chapter 742 (SB 1427, Escutia). Among other things, the bill established the requirement for an annual report to the Senate and Assembly Committee's on Insurance detailing the Insurance Commissioner's plan to inform the public about the availability of the CLCA pilot program. In 2004, Stats. 2004, Chapter 920 (SB 1500, Speier) added additional requirements for CDI to report on the success of the program.

In 2005, Stats. 2005, Chapter 435 (SB 20, Escutia) authorized expansion of the program to all counties in California at the discretion of the Commissioner, subject to specified procedures, and mandated commencement of operations in Alameda, Fresno, Orange, Riverside, San Bernardino and San Diego counties on April 1, 2006. As authorized by legislation, in 2007 CDI announced plans to expand the program to all counties within California. The statewide rollout of the CLCA program was completed as of December 10, 2007.

Eligibility criteria, policy attributes, rate-setting standards and other requirements regarding the CLCA insurance program are set forth in the California Insurance Code (CIC), commencing with Section 11629.7.

Insurance Commissioner Steve Poizner shares the Legislature's commitment to reduce the number of uninsured drivers on California's roads and to make affordable liability insurance available to all consumers. As such, the Commissioner has made the CLCA insurance program a key component of his Strategic Vision which consists of a series of CDI programs and activities that focus on improving access to and availability of insurance services in low-income communities.

The report that follows includes the Commissioner's assessment of the success of the program, details the activities and accomplishments of the past year, and outlines the consumer education and outreach plan for 2009.

The CLCA program provides an affordable auto insurance option for low-income, good drivers. The program is now available in all 58 counties within the State of California.

The California Automobile Assigned Risk Plan (CAARP) administers the CLCA program. CAARP assigns CLCA applications to licensed auto insurers based on each insurer's share of the California voluntary auto insurance market. Only producers (agents/brokers) certified by CAARP are authorized to submit program applications. Currently, there are approximately 5,400 producers certified by CAARP.

Policy Features

The basic CLCA liability policy limits, as prescribed by state law, are $10,000 for bodily injury or death per person in an accident, $20,000 for bodily injury or death per accident, and $3,000 property damage for each accident.

The annual premium rate for a CLCA liability policy varies by county. Several installment options are available, with a down payment as low as 15 percent of the total cost.

Eligibility Requirements

Applicant's annual household income may not exceed 250 percent of the federal poverty level.

An applicant must be a "good driver," defined as having no more than one at-fault property damage accident, or no more than one "point" for a moving violation, but not both, no at-fault accident involving bodily injury or death in the past three years; and no felony or misdemeanor conviction for a violation of the California Vehicle Code.

An applicant must be at least 19 years of age and a resident of the State of California.

The applicant must have been continuously licensed to drive for the previous three years. In meeting the three year standard, up to 18 months of foreign licensure is acceptable, providing the applicant was licensed to drive in the United States or Canada for the preceding 18 months.

The value of the vehicle to be insured may not exceed $20,000.

No more than two low-cost policies per person are permitted.

A CLCA policyholder may not purchase a non-CLCA liability policy for any vehicle in the household.

In 2005, AB 1183 (Vargas) authorized the use of up to five cents ($0.05) of the 10-cent fee imposed on insurers for the purpose of improving consumer functions, subject to budget approval, to inform consumers about the existence of any low cost automobile insurance program authorized in law. In fiscal year 2008-2009, the Department allotted $1,382,235.00 of these funds for the CLCA program.

2008 The Year in Review

The primary focus of the CDI's 2008 outreach activities was to continue to raise consumer awareness and increase the volume of program inquiries. This was accomplished in partnership with various community-based organizations, and state and local government agencies that serve those persons eligible for the program.

Consumer Education and Outreach Activities

The CDI participated in over 198 CLCA events during 2008. Advertising concentrated on community based and ethnic specialty press to reach low-income communities in the most economic way. CDI staff educated producers on program particulars and sought to increase their participation in the program. A more detailed description of the CDI's 2008 outreach activities is provided below.

Consumer Education and Outreach Materials Development and Distribution

In 2008, over 550,000 brochures were distributed to the general public, government agencies and community based organizations in the State.

Governmental Agency Collaboration

Efforts to integrate the CLCA program with other state and local governmental agencies that serve low-income residents continued. These efforts focused on the Los Angeles Department of Public and Social Services (LADPSS), the California Department of Motor Vehicles (DMV), Department of Human Services, EDD Centers, Head Start Centers, the Women Infants and Children (WIC) program, Housing Authorities, and Workforce Development programs throughout California.

Community Based Organizations

Throughout 2008, the CDI continued to develop relationships and partnerships with community based organizations in every county. CDI staff participated in a wide variety of events hosted by partner organizations ranging from Senior Citizen Organizations to work force agency events and street fairs. Program materials were distributed to community based organizations and the general public throughout California.

Producer Outreach

Department staff continued to participate in the training course of CAARP providing information to newly licensed producers on the California Low Cost Automobile Insurance Program.

In September 2008 a Community Auto Insurance Access Forum was conducted in Sacramento, California. The purpose of the forum was to bring together Community Based Organizations and insurance producers to help promote partnerships intended to increase access to auto insurance within the community.

Community Based Advertising Campaign

The consumer education and outreach plan utilized community based and the press, public service announcements, paid radio and television advertisements to advertise the CLCA program. The primary advertising goal was to select affordable publications and radio and television programs that targeted low-income communities within eligible counties.

Print Advertising

In an effort to reach the largest audience within eligible communities in the most cost-effective manner, the CDI elected to advertise in community based and ethnic-specialty press. These ads enabled the Department to promote consumer awareness across a broad spectrum of communities and to amplify consumer education and outreach efforts. The print advertising campaign was delivered in English and Spanish via publications in various counties.

Performance Measures and Statistics

2008 Calendar Year Program Statistics:

- Applications Assigned: 6,306
- Applications Received: 7,892
- Percentage of Applications Eligible for Assignment: 79.9%
- Policies in Force: 10,619
- Hotline inquiries: 94,366

Determination of Success

CDI has determined that the California Low Cost Automobile Insurance program was successful in meeting each of the measurements of success specified in California Insurance Code section 11629.85, as amended by SB 1500 (Speier), SB 20 (Escutia) and AB 1183 (Vargas).

1. Rates Were Sufficient to Meet Statutory Rate-Setting Standards

The California Insurance Code specifies that rates shall be sufficient to cover losses and expenses incurred by policies issued under the program. Rate-setting standards also require that rates shall be set so as to result in no projected subsidy of the program or subsidy of policyholders in one county by policyholders in any other county. Consistent with these standards, the program rates in effect during 2008 generated sufficient premiums to cover losses and expenses incurred by CLCA policies issued under each respective county program.

2. Program Served Underserved Communities

The CDI believes it is meeting this standard, as evidenced by the following: Household incomes of all policyholders do not exceed 250% of the federal poverty level. In fact, CAARP statistics document that 77% of policies issued in 2008 were issued to applicants whose household income was at or below $20,000 per year. 6,306 policies were assigned in 2008, thus providing access to an affordable insurance option for low-income households. An applicant's vehicle at the time of application can not exceed $20,000. The predominant vehicle value for policies issued in 2008 was less than $5,000.

3. Program Offered Access to Previously Uninsured Motorists, thus reducing the Number of Uninsured Drivers

Statistics compiled by CAARP demonstrate that, in 2008, 70% of new policies assigned were to applicants who were uninsured at the time of application. With the implementation of the CLCA, thousands of formerly uninsured drivers are now insured through the CLCA Program.

4. Administrative Costs

For fiscal year 2008-09, the Department allocated approximately $1,382,235.00 of SB 940 (Speier) and AB 1183 (Vargas) funds for CLCA consumer education and outreach activities. The CLCA program is administered by CAARP, whose administrative costs are reflected and reported in the accompanying annual CAARP report and budget.

Conclusion

CDI considers the California Low Cost Automobile Insurance program a component to making liability insurance affordable and available to all consumers in California, and is committed to the program's success. CDI believes the program shows promise in helping reduce the number of uninsured drivers on California roads.

Through the elements described in the 2009 Consumer Education and Outreach Plan, the CDI expects to further raise consumer awareness, increase the volume of inquiries about the program and the number of policies assigned.

CDI seeks to aggressively promote the program to underserved communities in order to make insurance affordable to more Californians.

CDI is committed to making the California Low Cost Automobile Insurance program a model for the nation.

The California Low Cost Automobile Insurance Program 2009 consumer education and outreach plan incorporates and builds upon the methods employed in the 2008 plan to meet the challenges of the program promotion within the State.

The core objective of the 2009 consumer education and outreach plan:

- Continue to develop and enhance consumer education and outreach activities within the State through partnerships with community-based organizations and government agencies.

To accomplish the 2009 plan, the CDI will continue to build upon its efforts to raise consumer awareness about the program in collaboration with community-based organizations, and government agencies. The CDI will also continue to utilize the media for the placement of advertisements, work with its marketing and public relations firm, and seek opportunities to increase producer and community participation.

The Department proposes to use approximately $1,410,000.00 of the funds allocated, pursuant to California Insurance Code Section 1872.8, to fund the consumer education and outreach plan for the CLCA program in fiscal year 2009-2010.

2008 ANNUAL REPORT

CONSUMER SERVICES AND MARKET CONDUCT BRANCH

CONSUMER SERVICES & MARKET CONDUCT BRANCH

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

CSMCB consists of two divisions and five bureaus:

Consumer Services Division (CSD)

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

Market Conduct Division (MCD)

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

Table A: CSMCB 2008 Calendar Year Results

Consumer Telephone Calls Received (automated call-center calls)	222,405
Complaint Cases Opened	37,513
Complaint Cases Closed	35,952
Total Amount of Consumer Dollars Recovered	$50,414,024
Number of Exams Adopted by the Commissioner	176
Total Amount of Claims Dollars Recovered or Premium Returned to Consumers	$11,993,673
Penalties Resulting from MCD Legal Actions in 2008	$4,700,000
CSMCB Grand Total Amount (Consumer Dollars Recovered, Claims Dollars Recovered or Premium Returned to Consumers, and Penalties Resulting from Legal Actions in 2008)	**$75,013,009**

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 2008, 106 fulltime staff are devoted to the complaint handing operation. This represents 8% of the 1336 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 Worker's 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 Worker's 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. In 2008, several natural disasters occurred in the state.

A series of Southern California wildfires began in March and continued through November of 2008. At one point, 1500 fires were burning during a single 24 hour period between June 20th and the morning of June 21st, 2008. Some of the most notable fires included the Tea, Sayre-Sylmar, Ophir, Summit, Triangle, and Sesnon/Merek fires. Insurers have reported that there were about **6,238** claims filed, **$640,037,525 Million** in potential insurer exposure, and about **$447,239,383 Million** paid by insurers through April 2009. The Consumer Services Divisions responded in several areas. CSD dispatched more than 35 professional staff that spent 48 days at 11 Disaster Recovery Centers and workshops to assist survivors with insurance questions and helping to get insurers to pay claims as quickly as possible. CSD also investigates complaints received from fire survivors. The Division has received approximately 110 complaints and recovered $1,169,949 for consumers.

Additionally, CDS staff continued to work on the 2007 fire storm complaints and issues and conducted workshops in San Diego County, meeting with total loss survivors and assisting them with technical insurance questions and issues. The division assisted approximately 626 consumers and recovered $29,258,228 on their behalf.

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

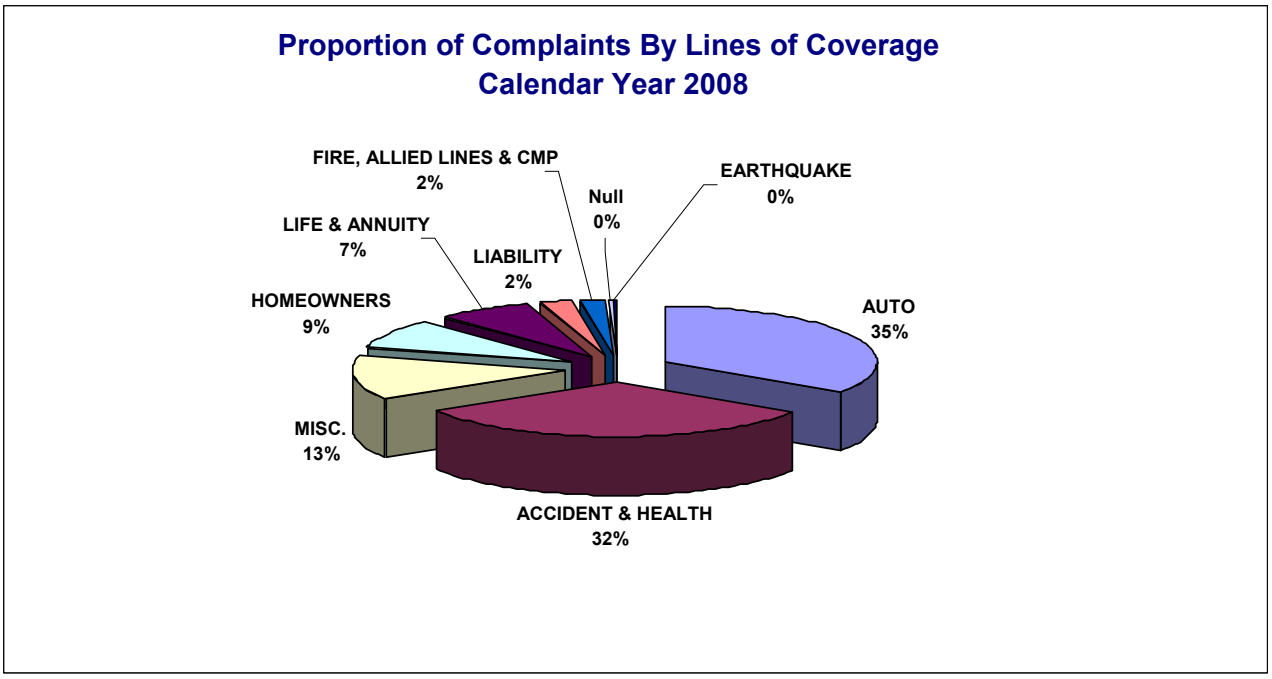
Consumer Complaint Trends

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

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

Coverage Type	2006	2007	2008
AUTO	40.13%	37.77%	34.43%
ACCIDENT & HEALTH	25.91%	30.42%	31.76%
MISC.	13.93%	13.12%	12.90%
HOMEOWNERS	7.41%	7.16%	8.80%
LIFE & ANNUITY	7.23%	6.80%	7.23%
LIABILITY	2.82%	2.34%	2.43%
FIRE, ALLIED LINES & CMP	1.90%	1.61%	1.82%
Null	0.27%	0.28%	0.36%
EARTHQUAKE	0.40%	0.49%	0.27%

The overall percentage of accident & health complaints has been increasing slightly over past years, while the percentage of auto complaints has been decreasing over the past years.



The pie graph above shows the proportion of complaints by lines of coverage for calendar year 2008.

Auto	35%
Accident & Health	32%
Miscellaneous	13%
Homeowners	9%
Life and Annuity	7%
Liability	2%
Fire, Allied Lines & CMP	2%
Null	0%
Earthquake	0%

Table C: Top Ten Types of Complaint Reasons (2006-2008)

#	Types of Complaint Reasons	2006	2007	2008
1	Denial of Claim	17%	14%	17%
2	Claim Handling Delay	4%	6%	10%
3	Unsatisfactory Settlement Offer	5%	5%	6%
4	Other - Claim Handling	6%	5%	5%
5	Premium & Rating / Misquotes	4%	5%	5%
6	Premium Refund	8%	7%	5%
7	Coverage Question	2%	3%	5%
8	Cancellation	5%	6%	5%
9	Premium Notice/Billing Problem	5%	5%	5%
10	Agent Handling	6%	6%	5%
	Total:	**61%**	**63%**	**68%**

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; chairs 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 to program to include automobile physical damage and residential property disputes subject to specific guidelines. Since the program's inception in 1996 through December 31, 2008, the Mediation Program has recovered *$15,323,050* for consumers. In accordance with CIC 10089.83, the following is a report of the results of the program for the calendar year 2008:

Table D: 2008 Residential Property, Earthquake, and Automobile Mediation Program Results

	Residential	Earthquake	Automobile	Totals
Number of mediation cases eligible	28	0	3	31
Number settled within 28 day settlement period	4	0	1	5
Number sent to mediation	12	0	2	14
Number of cases rejected by insurer	9	0	0	9
Number accepted by insurer	12	0	2	14
Number of settlements rejected within 3 day waiting period	0	0	1	1
Amount initially claimed	$829,731	0	$33,374	$863,105
Amount of settlements	$409,950	0	$22,333	$432,283

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 worker's 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.

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 2008

Rank	Complaint Type/Reason	# of Complaints
1	Premium & Rating / Misquotes	700
2	Coverage Question	470
3	Premium Refund	290
4	Cancellation	287
5	Premium Notice/Billing Problem	276
6	Surcharge	263
7	Nonrenewal	261
8	Agent Handling	113
9	Other - Policyholder Service	74
10	Other - Underwriting	56
11	Policyholder Service Delays no response	20
12	Information Requested	15
13	Policy Audit Dispute	15
14	Misrepresentation	14
15	Refusal to Insure	12
16	All Other Reasons	132
	Total:	**2,998**

Table F: (CIC) Section 1858.35 Complaints by Final Disposition: 2008

Rank	Final Disposition	# of Complaints	Recovery Amount *
1	Company Position Upheld	1794	$314,834
2	Premium Refund	196	$607,598
3	Advised Complainant	153	$11,964
4	Question Of Fact	139	$26,298
5	Other	113	$2,268
6	Premium Problem Resolved	98	$66,175
7	Policy Issued/Restored	61	$64,471
8	Underwriting Practice Resolved	61	$29,477
9	Information Furnished/Expanded	52	$0
10	Non-renewal Notice Rescinded	45	$0
	All Other Reason Codes	286	$614,635
	Total:	**2,998**	**$1,737,720**

** Recovery Amount to Consumers*

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.

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 2008. 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 2008

Examination Results Category	FCB	FRUB	MCD Totals
Number of Exams Adopted by the Commissioner	69	107	176
Amount of Claims Dollars Recovered or Premium Returned to Consumers	$3,696,898	$8,296,775	$11,993,673

Legal Actions & Penalties	FCB	FRUB	MCD Totals
No. of Actions Finalized by Legal Branch due to MCD Exam Findings	6	1	7
Penalties Resulting from Legal Branch in 2008	$4,450,000	$250,000	$4,700,000

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.

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 2008. Specifically, 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 complaints in 2007 (ranging from 715 at the top to 303 at number 10) have been examined in the last 3 years or will be examined in the next 2 years (3 completed, 6 in progress, 1 on schedule). Additionally, several of the insurers identified with high complaint totals are scheduled for examination more than once during this 5 year timeframe. Five of the ten have been the subject of enforcement actions within the last 3 years and 2 are under consideration for further action.

Complaints by line of business continue to be an important area for focusing Market Conduct Division examination resources. The Department received 37,513 complaints in 2008. The top five lines of business which generated the most complaints were the following: private passenger auto (12,624), group accident and health (7,962), (3,187), homeowners, individual accident and health (2,834), and individual life (2,122). These lines of business were the most frequently examined by both the Field Claims Bureau and the Field Rating and Underwriting Bureau during 2008. 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 2008. 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 2009.

PATIENT AND PROVIDER PROTECTION ACT UNIT

Item 0845-001-0217—California Department of Insurance

1. ***Patient and Provider Protection Act Unit.*** *The California Department of Insurance (CDI) shall submit calendar-year annual reports on or before July 1, 2007, July 1, 2008, and July 1, 2009, to the Senate Health Committee, the Assembly Health Committee, and the Joint Legislative Budget Committee concerning the number, types, and status of health care provider, consumer, and other complaints processed each year under the provisions of Chapter 441, Statutes of 2005 (SB 634, Speier), and Chapter 723, Statutes of 2005 (SB 367, Speier). To the extent possible, CDI should provide this report in a format similar to that used by the Department of Managed Health Care in similar reports.*

SB 367 and SB 634 became effective January 1, 2006. SB 367 amended and adopted various sections of the California Insurance Code (CIC) to create the Patient and Provider Protection Act. In order to implement SB 367 and SB 634, the Department: (1) developed a Request for Assistance form specific to providers to be used by providers in filing complaints with the CDI; (2) developed a web page, located on the CDI's public web site, which is specific to health insurance and health care providers; (3) developed and posted a list of all insurers providing health insurance coverage on our public web site; (4) developed and published a Health Care Provider's information guide to the Complaint Process; (5) sent out a notice to all health insurers advising each of the dispute resolution process reporting requirement, as per Insurance Code Section 10123.137(d); and hired and trained CDI staff on the handling of provider complaints.

I. Total Numbers and Types of Complaints handled under SB 634 and SB 367

For Calendar Year 2008, CDI received more than 6,712 complaints relating to health insurance related matters. In addition to the complaints received and investigated in CY 2008, CDI's Consumer Services Division staff handled several cases involving several health insurers, which affected more than 2,807 providers and thousands of patients.

Table A describes the types of healthcare provider complaints received by the CDI.

Table A: SB 367 Healthcare Complaint Types (Calendar Year 2008)

Reason Description	Percentage of all Healthcare Provider Complaints Received by the CDI
Denial of Claim	33%
Unsatisfactory Settlement Offer	18%
Claim Handling Delay	12%
Other - Claim Handling	7%
Usual, Customary Reasonable	6%
*All Other Reasons Combined	25%

**CDI tracks all complaints using a coding system standardized through the National Association of Insurance Commissioners (NAIC). Other Reasons may include prompt pay, forced placement audit dispute health status, unfair discrimination, rescission, etc*

II. Other Regulatory Actively Related to SB 367 and SB 634

A. Market Conduct Examination of Health Insurers

For Calendar Year 2008, the CDI's Market Conduct Division, Field Claims Bureau completed 18 market conduct examinations of Health Insurers. Twelve of these exams have resulted in a referral to the CDI's Legal Division for potential enforcement action for violations of the various health insurance laws. However, until such time as an order or enforcement action is filed, the names of the insurers and the substance of the actions cannot be made public. The Field Rating and Underwriting Bureau completed 20 insurer market conduct examinations of Health Insurers. Further action is pending upon review.

B. Legal Division, Health Enforcement Bureau Activities

As a result of SB 367, in September 2006, the CDI recruited and hired a staff counsel with special expertise in health insurance and health care provider issues. The CDI created the Health Enforcement Bureau to provide legal assistance to the Consumer Services and Market Conduct functions, undertake health enforcement actions under a range of insurance statutes pertaining to claims settlement practices and provider protections, prepare proposed regulations to clarify and make specific statutes governing health insurance rescissions, and research legal questions concerning statutes governing individual and small group health insurance.

In 2008, the Health Enforcement Bureau handled more than 23 separate legal matters including key enforcement actions against the State's largest health insurers. In 2008, three significant settlements were reached involving alleged illegal health insurance rescissions and related improper claims handling. These actions resulted in $4.6 million in up front penalties paid to the State as well as recoupment of legal fees incurred in prosecuting these actions. An additional $10.6 million in penalties may be due to the Department if these companies fail to meet the requirements set forth on the corrective action plans to be approved by the Department and called for in the settlements.

More importantly, as a result of these three key enforcement actions, more than 4,000 individuals whose insurance was rescinded between January 1, 2004 and December 31, 2008 will receive offers of health insurance coverage in 2009 without regard to their possible pre-existing conditions. These former insureds can also request reimbursement of out of pocket medical expenses they incurred as a result of the rescission of their health insurance coverage. The health insurers who settled these enforcement actions - Health Net Life, Blue Shield Life and Anthem Blue Cross Life and Health - are barred from using the validity of the rescission as a defense in their adjudication of the reimbursement requests. These no-fault restitution agreements which include both an offer of money paid to former insureds and an offer of health insurance coverage are unprecedented in the history of the Department.

In addition, each of these three health insurers, who represent approximately 85% of the individual health insurance market's covered lives, were required in these settlements to submit corrective action plans which cover a wide range of detailed procedures critical to how the companies conduct medical underwriting of health insurance applications, claims handling, rescission investigations and related matters in a compliant manner. All have agreed to install an Independent Third Party organization to review proposed rescissions and to abide by the reviewing organization's recommendation.

In 2008 the Commissioner's Health Enforcement Bureau filed a major action against PacifiCare Life and Health Insurance Company alleging many thousands of claims handling violations and allegations related to failure to properly resolve provider disputes, failure to manage provider contracting processes and improper management of pre-existing condition exclusions in health insurance policies. This case and others are still pending.

In 2008 the Health Enforcement Bureau staff analyzed many important pieces of health related legislation and rendered several key legal opinions and responses regarding matters brought by agents, insurers, consumers and providers to the Department for interpretation and resolution. Some of these matters were resolved through negotiation thereby avoiding non compliance with the Insurance Code and the cost to the Department of filing a formal enforcement action.

This Bureau has also provided information to health insurers to help them better comply with consumer protections within certain health insurance statutes. As a direct result of the investigation of provider complaints handled by the Consumer Services and Market Conduct divisions several Legal Services Requests were submitted to the Health Enforcement Bureau for legal opinions and/or enforcement actions. As of the writing of this report, more than eight (8) enforcement actions have been filed against health insurers. All of these actions are pending. Also, the Health Enforcement Bureau works collaboratively with legal counsel at the Department of Managed Health Care (DMHC) in coordinating legal issues, public policy matters and enforcement activities to increase consistency for organizations offering both DMHC and CDI regulated products.

C. Independent Medical Review Program (IMR)

The IMR program became effective in 2001, with the passage of AB55 (1999), and Insurance Code Section 10169. Table A, below describes the number of potential IMR cases received by the CDI from CY 2001 through CY 2008.

Table B: IMR Activity by CDI

Calendar Year	Cases Received
2001	120
2002	300
2003	323
2004	365
2005	390
2006	520
2007	975
2008	1287

2008 ANNUAL REPORT

ENFORCEMENT BRANCH

ENFORCEMENT BRANCH ANNUAL REPORT INSURANCE CODE SECTIONS 1872.9, 1872.96, 1874.8 FISCAL YEAR 2007-08

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 2007-08. 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 Insurance Investigator (Investigation Division), one Staff Services Manager II (Fraud Division), one Supervising Fraud Investigator II (Fraud Division), and an Executive Assistant.

Branch Headquarters – The Staff Services Manager II 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 – The Supervising Fraud Investigator II oversees all internal affairs investigations for the Department and pre-employment background investigations for the Branch.

Computer Forensic Team – The Supervising Fraud Investigator I coordinates the efforts of the Computer Forensic Team that supports statewide investigative efforts through technical expert forensic examinations of computer data seized during investigations.

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 2007-08, the Investigation Division's expenditures totaled $9,664,032.73 in support of an authorized staff of 90.8 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 priority 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 current product lines used to abuse seniors are the single premium annuity and long term care insurance.

- 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 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 priority types, 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 2007-08, 1,696 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 795 different individuals and/or entities.

- 184 additional complaints were consolidated within the investigation of the 795 investigations, which were opened.
- Cases opened against 756 different individuals and/or entities were completed during Fiscal year 2007-08
- 780 Cases were still in progress as of June 30, 2008.
  (Criminal Cases: 490)
  (Regulatory/Administrative Cases: 290)
- 370 Reports of Suspected Violation[1] were pending as of June 30, 2008.
  (Criminal Cases: 136)
  (Regulatory/Administrative Cases: 234)

During Fiscal Year 2007-08, the Investigation Division has identified and reported chargeable fraud of $96,856,165, ordered restitution of $69,061,975, investigative cost recoveries of $989,662 and fines and penalties of $12,459,952.

CRIMINAL PROSECUTION CASES

Assisted Law Enforcement Agencies ……..…..26

Referred to Prosecutor. ……..….81

Filing/Arrests/Indictments ……...…75

Search Warrants Served …….27

Convictions/Sentencing ……..…....97

REGULATORY PROSECUTION CASES

Cases Referred for Regulatory Prosecution: …140

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.

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[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.*

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: ……..140

Completed: …….149

In progress as of June 30, 2008: 194

Reports of Suspected Violation: ……55

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.

CIC § 10127.17 assesses a $1.00 fee against insurers for each new individual life insurance and annuity product worth $15,000 or more and requires that the moneys be deposited into the new Fund. The Fund will be used to protect consumers of life insurance and annuity products from financial abuse. The bill allows an insurer to charge this fee to the policyholders but requires that the insurer charge it separately from other premiums or other fees. Moneys collected will be equally divided between the Department and district attorneys for investigating and prosecuting violators and for other projects beneficial to insurance consumers. This bill provides that the Commissioner may develop guidelines and issue regulations for implementing these provisions.

LIFE INSURANCE AND ANNUITY PRODUCTS INVESTIGATIONS[3]

Opened: 152

Completed: 124

In progress as of June 30, 2008 156

Reports of Suspected Violation: 75

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[2] *This data is included in the overall Division case information shown on the previous sections of this report.*
[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 Department has implemented the following:

- Expanding the Criminal Operations Point of Sale Unit. This 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.
- Establishing investigative time parameters and case referral objectives to improve efficiency and increase productivity.
- Establishing Investigation Division Disaster Response Team to work in conjunction with other CDI Divisions and allied agencies to proactively respond to disasters or other emergencies statewide affecting enforcement operations.
- Developing a paperless work environment to expedite the processing of complaints and reports of suspected violations received by Investigation Division.
- 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 2007-08, 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 2007-08 Fraud Division Budgeted/Revenue/Expenditures by Program and Fiscal Year Staffing level:

Fraud Auto Revenues: [4] $37,567,273

Insurance Fraud Assessment, Auto
- Budgeted Levels:.....$39,459,000
- District Attorneys' Auto Distribution: $18,834,968
- State Operations Auto Expenditures: $17,659,733

Insurance Fraud Assessment, Workers' Compensation
- Budgeted Levels:.....$45,336,000
- District Attorneys' Workers' Compensation Distribution:....$25,080,000
- State Operations Workers' Compensation Expenditures:..$20,536,116

Insurance Fraud Assessment, Disability and Healthcare
- Budgeted Levels:.....$4,115,000
- District Attorneys' Disability and Healthcare Distribution: ..$2,029,645
- State Operations Disability and Healthcare Expenditures: $1,870,230

Insurance Fraud Assessment, General
- Budgeted Levels:.....$2,282,000
- State Operations General Assessment Expenditures:.....$2,346,284
- Fiscal Year 2007-08 Fraud Division Positions: 291.0

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

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

AUTOMOBILE INSURANCE FRAUD

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

Fraud Division criminal investigators 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 2007-08, the Fraud Division received 14,623 suspected fraudulent claims (SFCs), assigned 504 new cases and made 177 arrests, and submitted 206 submissions to prosecuting authorities. The potential loss amounted to $176,330,395.

District Attorneys' Automobile Insurance Fraud Program

During Fiscal Year 2007-08, 34 counties received funding totaling $13,050,212 through the Department's Auto Insurance Grant Program. The amount of financial support funded to each county is derived from three components: county population, the number of SFCs reported, and a plan to utilize the grant funding.

For Fiscal Year 2007-08, the district attorneys initiated 1,909 investigations and made 748 arrests, culminating in 790 convictions, which includes the Fraud Division's enforcement actions, and local law enforcement investigations.

Chargeable fraud amounted to $11,028,589, with $1,776,690 in restitution ordered by the courts.

ORGANIZED AUTOMOBILE FRAUD ACTIVITY INTERDICTION

The California State Legislature finds that organized automobile fraud activity operating in the major urban centers of the state represents a significant portion of all individual fraud-related automobile insurance cases. These cases result in artificially higher insurance premiums for core urban areas and low-income areas of the state than for other areas of the state. 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. The California Insurance Code Section 1874.8 mandates the Insurance Commissioner award three to ten grants for a coordinated program targeted at the successful prosecution and elimination of organized automobile fraud activity. The primary focus of the program is directed at the organized criminal activity that occurs in urban areas and which often involves the staging of automobile accidents and the filing of fraudulent automobile accident or damage claims.

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

During Fiscal Year 2007-08, the Fraud Division assigned 227 new cases and made 274 arrests with 315 submissions to prosecuting authorities. Potential Loss amounted to $5,951,672.

District Attorneys' Organized Automobile Fraud Activity Interdiction Program

During Fiscal Year 2007-08, nine counties were awarded grant funding totaling $5,784,756. The grant-awarded district attorneys reported 249 arrests, which included many of the Fraud Division arrests. District attorneys prosecuted 284 cases involving 523 defendants with chargeable fraud totaling $10,943,518.

District attorney outcomes totaled 287 convictions.

DISABILITY AND HEALTHCARE FRAUD

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.[5]

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 ten 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.

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[5] *California Insurance Code §1871 (h).*

During Fiscal Year 2007-08, the Fraud Division identified and reported 351 SFCs, assigned 65 new cases and made 17 arrests with 17 submissions to prosecuting authorities. Potential Loss amounted to $11,224,976.

District Attorneys' Disability and Healthcare Program

In Fiscal Year 2007-08, five counties received funding totaling $2,029,645 through the Department's Disability and Healthcare Insurance Fraud Grant Program. The district attorneys reported 184 investigations, 45 arrests, and 37 convictions, which also included a majority of Fraud Division arrests. Chargeable fraud amounted to $148,377,265, with $9,811,925 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 2007-08 is $43,887,233.

During Fiscal Year 2007-08, the Fraud Division identified and reported 4,973 SFCs, assigned 515 new cases, made 375 arrests and referred 432 submissions to prosecuting authorities. Potential Loss amounted to $292,390,871.

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 2007-08, the district attorneys reported a total of 583 arrests, which also included the majority of Fraud Division arrests. During the same time frame, district attorneys prosecuted 1,063 cases with 1,196 suspects, resulting in 527 convictions. Restitution of $23,611,264 was ordered in connection with these convictions and $10,348,834 was collected during Fiscal Year 2007-08. The total chargeable fraud was $270,465,234, 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 approximately for 5 percent of the Fraud Division's allocated budgetary resources. The funding stream for this program is generated by 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 2007-08, the Fraud Division identified and reported 3,787 SFCs, assigned 106 new cases, made 26 arrests and referred 28 submissions to prosecuting authorities. Potential Loss amounted to $674,193,938.

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 2007-08, the SIU Compliance Review Office audit staff conducted 32 on-site audits of primary insurance companies which included 59 subsidiary companies, for a total of 91 insurers. Of the 91 companies reviewed, 15 were authorized to write and are currently writing workers' compensation insurance in California. Twenty-four of the 32 primary companies reviewed were 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 to enhance the 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) requires 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 grant program, the programs are audited concurrently to maximize efficiency.

During Fiscal Year 2007-08, the FGAU examined 15 district attorneys' offices and completed 35 insurance fraud grant audits (specifically, 15 Workers' Compensation; 15 Automobile; 5 Organized Automobile).

Common findings of the FGAU reviews include:

- expenditures inaccurately reported
- expenditure report not submitted as required
- modified budget not submitted as required
- salaries and benefits inadequately documented

After the FGAU completes its analysis, a preliminary audit 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 Deputy Commissioner of the Enforcement Branch, Bureau Chief, Regional Office Captain, Legal Division, Enforcement Branch Headquarters Chief, and Local Assistance Unit 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 2007-08, Fraud Division received the following number of Suspected Fraudulent Claims (SFCs) by program:

Auto and Urban Auto	14,623
Property Casualty	3,787
Workers' Compensation	4,973
Health	351
Total	**23,734**

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

SFCs unassigned due to insufficient evidence: 14,705

SFCs unassigned due to other reasons: 7,071

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 ……...26

Suspect Submissions to District Attorneys……..….28

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

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

Type of Insurance	Amount Paid[1]	Suspected Fraudulent Loss[2]	Potential Loss[3]
Automobile	$19,278,309	$76,327,130	$176,330,395
"Urban Auto"	$833,390	$3,062,750	$5,951,672
Health	$11,551,852	$7,744,855	$11,224,976
Property Casualty	$524,445,049	$27,677,805	$674,193,938
Workers' Compensation	$213,022,962	$161,966,820	$292,390,871
TOTALS	**$769,131,562**	**$276,779,360**	**$1,160,091,852**

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

Type of Insurance	Restitution Ordered	Restitution Collected
Automobile	$1,803,262	$631,750
"Urban Auto"	$2,631,851	$698,178
Health	$9,811,925	$33,018
Workers' Compensation	$23,515,914	$10,348,834

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: 375

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 2007-08, the DAR was enhanced with a new 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 2008-09 Budget (Local Assistance*)*

On September 11, 2007, the FAC voted to increase district attorney grant funding (Fiscal Year 2008-09) by $4,020,000, thereby increasing the total amount to $29,100,000. 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 2008-09 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.

Another change implemented for the 2008-09 application cycle was reducing the number of RFA copies the applicants were required to submit from seven to three. This request to streamline the process was based on requests from district attorney's staff.

Workers' Compensation Fraud Research Study

In its April 29, 2004 report, the Bureau of State Audits (BSA) recommended that the Fraud Division and the FAC conduct the research necessary to fulfill its statutory role as an advisor regarding the level of funding and the direction of fraud reduction efforts. These efforts include: 1) measuring the nature and extent of fraud in the workers' compensation system and the effectiveness of anti-fraud efforts 2) monitor the performance of county district attorneys who receive grants of fraud assessment funds, and 3) conduct the research necessary to meet its advisory and reporting responsibilities.

On July 27, 2006, the FAC commissioned Navigant Consulting, Inc. to conduct a research study with the purpose to determine the extent of workers' compensation medical overpayments and underpayments to justify and provide information on the appropriate allocation of resources to detect and evaluate suspected medical provider fraud in California. This research study was also to provide recommendations for ongoing detection and monitoring of suspected fraud and abuse in the system.

Navigant's general approach to the study was to review a specified random sample of workers' compensation medical bills and supporting documentation for medical services paid by insurance carriers and claims administrators as well as to conduct a survey of injured workers to verify receipt of services. Navigant has selected a random sample of injured workers from the Workers' Compensation Information System of the Division of Workers' Compensation. On April 13, 2007, a request for data elements on medical bills from insurance carriers, self-insured employers, and third party payers for the period of January 1, 2006 through June 30, 2006 was sent out to all workers' compensation insurers and the self-insured. Navigant captured medical bills from various stages following the initial reporting of a worker's injury by selecting random samples from the Workers' Compensation Information System for several years from the California Workers' Compensation Institute. The data was audited, reviewed, and compiled. This research study was completed on June 17, 2008.

Navigant's research study concluded that, of their research sample, 35.1 percent of medical bills submitted to insurance companies by physicians (and other practitioners), hospitals, and pharmacies contain billing errors. These errors consisted of:

- Services not medically necessary
- Services were not supported by medical documentation
- Diagnosis was not related to worker's injury
- Incorrect procedure codes and modifiers
- Billing for non-reimbursable services
- Duplicate billing

The first three errors listed comprised 71 percent of the total errors and comprised 61 percent of the total dollar value of the errors.

Navigant also determined that 23.1 percent of the medical payment dollars sampled were paid in error. When extrapolating the research sample errors, Navigant estimated the dollar amount of medical payment errors in the entire California workers' compensation system to be $1.5 billion dollars.

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.

Fiscal Year 2007-08 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 2007-08, the Fraud Division received 4,973 Suspected Fraudulent Claims (SFC) for the workers' compensation program. The reported losses[6] entered on the completed SFCs were as follows: $292,390,871 - Potential Loss, $161,966,820 - Suspected Fraud, $213,022,962 - Actual Paid, and $35,001,335 - Premium Fraud Loss.

There were 515 new cases assigned to Fraud Division investigative staff, bringing the overall total caseload to 1,319 for the fiscal year. The Fraud Division investigators and allied agencies executed 34 search warrants resulting in 391 workers' compensation cases submitted for prosecution. There were 375 suspects arrested and 204 defendants were convicted.

Objective: Reduce Incidents of Employer Misrepresentation (437 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.

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[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 Medical Provider Fraud (59 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.

The Fraud Division created a report to identify those providers who were consistently referred for suspected fraudulent activity. Although this report was initially requested for the Los Angeles County District Attorneys' Fraud Interdiction Program, copies of the report were sent to each Fraud Division Regional Office. While the results from these reports are still pending, arrests have been made and additional arrests are expected.

Objective: Reduce Incidents of Employers Defrauding Employees (42 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.

Outreach training to Uninsured Employers Fund (UEF) claim staff was carried forward to Fiscal Year 2007-08 in San Francisco, Sacramento, and Los Angeles. Instruction was designed to provide insight on employers who are found in violation of Labor Code 3700.5. Although it was found that most of the claims submitted are two or more years old when received, the Fraud Division will continue to review the claims.

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

Some of these recommendations can be implemented immediately, while others will require some changes in current statutes and regulation.

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 2007-2008

Fraud Activity Type	Total Caseload
Claimant Fraud	714
Insider Fraud	12
Employer Defrauding Employee	42
Legal Provider	8
Medical Provider	50
Misclassification	41
Other Workers' Compensation	55
Pharmacy	1
Under Reported Wages	125
Uninsured Employer	265
X-Mod Evasion	6
GRAND TOTAL	**1,319**

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 Investigators.

Private Outreach

During Fiscal Year 2007-08, the Fraud Division has actively participated with the California District Attorneys Association (CDAA) in two-day SIU training sessions held in Pleasanton and Anaheim. This training was designed to bring together those who investigate, prosecute, or are targets of insurance fraud to address common issues relative to the effective investigation, regulation compliance, and prosecution of fraud cases. Those who attended include SIU staff, investigators, and district attorney staff.

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:

- SIU Roundtable with Fresno County (July 2007)
- Southern California Fraud Investigators Association Conference (July 2007)
- Multi-Agency Meeting with Amador County (July 2007)
- SIU Roundtable with Orange County (August 2007)
- Senior Fraud Fest with San Mateo County (September 2007)
- SIU Roundtable with Alameda County (December 2007)
- Return to Work Administrators with Los Angeles County (December 2007)
- Northern California Fraud Investigators Association Conference (December 2007)
- Watsonville Law Center Collaborative Workers' Compensation Meeting (February 2008)
- SIU Roundtable with Santa Clara County (February 2008)
- SIU Roundtable with Fresno County (March 2008)
- SIU Roundtable with Kern County (March 2008)
- Los Angeles Police Department Workers' Compensation Training (March 2008)
- Fraud Symposium with Butte County (May 2008)
- Northern California Workers' Compensation Forum (May 2008)

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.

On September 4-7, 2007, the Fraud Division participated in Labor Rights Week, a training seminar targeting Mexican nationals working in the United States presented by the Mexican Consulate and the U.S. Department of Labor. The goal of the seminar was to: 1) Educate and inform workers and the public on workers' compensation laws; 2) Explain entitlements to workers' compensation benefits if injured on the job; 3) Explain the laws regarding unlawful denial of workers' compensation benefits; 4) Explain claimant fraud; and, 5) Develop leads on premium fraud or unlawful denial of workers' compensation benefits allegations. Over two thousand people attended and received information at the seminar held at the Consulate and more than 260 employment related cases were registered during a telethon held at Univision television in conjunction with the seminar.

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.
- 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 program.

For fiscal year 2007-08, the total number of SFCs is reported at 4,973. The table below reflects how this compares to previous fiscal years.

Fiscal Year	Suspected Fraudulent Claims
2002-03	3,544
2003-04	5,122
2004-05	6,492
2005-06	8,509
2006-07	5,933
2007-08	4,973

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 FY 2007-08, examples include four separate investigations resulting in arrests and convictions where fraudulent brokers embezzled more than $3.4 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 2007- 08 through Fiscal Year 2009 - 10 Budget

	2007- 08 Actual	2008 - 09 Projected	2009 - 10 Proposed
Personnel Years	118.5	122.0	125.0
Personal Services	$11,730,246	$11,925,962	$12,283,741
OE & E	$4,878,888	$4,543,733	$4,834,608
Research Study	$39,361	$0	$0
CDI Administrative Support	$3,887,621	$4,017,280	$4,097,626
Total	**$20,536,116**	**$20,486,975**	**$21,215,974**
FAC Approved Level	$19,890,000	$20,284,268	N/A
Fees & License Supplement	($646,116)	($202,707)	N/A

PROGRAM SUPPORT

Fraud Division

The Department of Insurance spent 20.8 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 2007-08 was $907,296.

- **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 recoup 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.

- **Budget and Revenue Management Bureau (BRMB)** – The Budget and Revenue Management Bureau prepares and monitors the Fraud Division's annual budget and other financial documents submitted to the Department of Finance. BRMB coordinates with the Fraud Division's administrative management and staff on the Fraud Division's spending plan and budget change proposals.

  During the 2007-08 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 2007-08 and 2008/09.

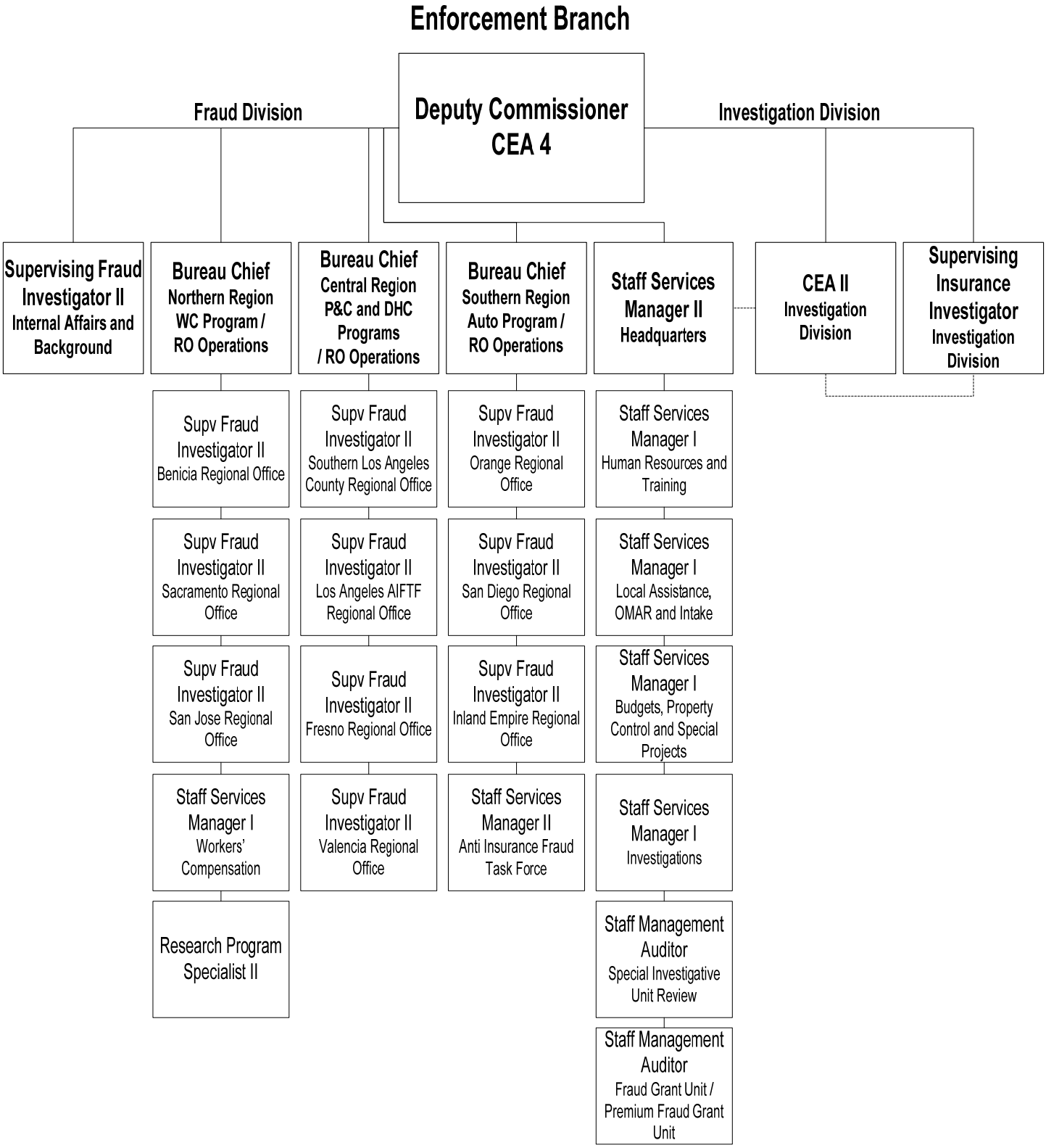
- **Human Resources Management Division (HRMD) –** Human Resources Management Division assists the Fraud Division's management and staff with the hiring, promoting, and transferring of employees. HRMD is also responsible for the Fraud Division's training, health and safety programs, timekeeping, and 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 is responsible for the upkeep of the Department's website.

Staffing

- In Fiscal Year 2007-08, the Fraud Division expended 118.5 workers' compensation personnel years. (See Organization Chart).



Enforcement Branch Organizational Chart (Text Version)

Fraud Division

- Supervising Fraud Investigator II - Internal Affairs and Background
- Bureau Chief - Northern Region WC Program/RO Operations
  - Supv Fraud Investigator II - Benicia Regional Office
  - Supv Fraud Investigator II – Sacramento Regional Office
  - Supv Fraud Investigator II – San Jose Regional Office
  - Staff Services Manager I – Workers' Compensation
  - Research Program Specialist II
- Bureau Chief - Central Region P&C and DHC Programs/RO Operations
  - Supv Fraud Investigator II – Southern Los Angeles County Regional Office
  - Supv Fraud Investigator II – Los Angeles AIFTF Regional Office
  - Supv Fraud Investigator II – Fresno Regional Office
  - Supv Fraud Investigator II – Valencia Regional Office
- Bureau Chief - Southern Region Auto Program/RO Operations
  - Supv Fraud Investigator II – Orange Regional Office
  - Supv Fraud Investigator II – San Diego Regional Office
  - Supv Fraud Investigator II – Inland Empire Regional Office
  - Staff Services Manager II – Anti-Insurance Fraud Task Force
- Staff Services Manager II – Headquarters
  - Staff Services Manager I – Human Resources and Training
  - Staff Services Manager I – Local Assistance, OMAR and Intake
  - Staff Services Manager I – Budgets, Property Control and Special Projects
  - Staff Services Manager I – Investigations
  - Staff Management Auditor – Special Investigative Unit Review
  - Staff Management Auditor – Fraud Grant Unit/Premium Fraud Grant Unit

Investigations Division

- CEA II
- Supervising Insurance Investigator

<u>Distribution of Workers' Compensation Program Hours</u>

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 four statewide anti-fraud programs under the administration and the investigative arm of the Fraud Division. For Fiscal Year 2007-08, investigative staff spent 82 percent of program hours on case and direct/program support; the remaining 6 percent was indirect time and 12 percent time off.

The Division spent 49 percent of its time directly on the Workers' Compensation Program, while the remaining 51 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 inspects insurance companies to ensure regulatory compliance in regards to the establishment, maintenance and operations of the insurer's SIU program. The office also updates, distributes, reviews, monitors and tracks the annual SIU compliance reports filed by approximately 1,300 insurance companies each year.

SIU Compliance Review Office – 2007-08 Fiscal Year

The SIU Compliance Review Office audit staff conducted 32 audits of primary insurance companies, which included 40 subsidiaries, for 72 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 72 total insurance companies reviewed, 12 were authorized to write and are currently writing workers' compensation insurance in California. Twenty-four of the primary companies reviewed were located outside of California.

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 cases of suspected fraud reported to district attorneys, CDI
- 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
- 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

New Audit Procedures

Premium fraud is a real concern to the industry and CDI. The SIU Compliance Office has expanded the scope of SIU compliance reviews to include examinations of active and canceled policy files and premium audit results when conducting SIU compliance reviews at companies that write workers ' compensation insurance in California. The policy examination procedures provide for the identification of policies, which may contain evidence of possible suspected insurance fraud warranting a referral to and investigation by the insurer's SIU. The procedures also help to identify incidents of suspected workers' compensation premium fraud, which should have been referred to the CDI Fraud Division and district attorneys but were not.

Fraud Grant Audit Unit (FGAU) 2007-08 Fiscal Year

The Fraud Grant Audit Unit (FGAU) staff completed the audits of 15 district attorneys' offices during the 2007-08 fiscal year. Common audit findings of the workers' compensation insurance fraud grants are indicated below.

Common Findings:

- Inaccurate expenditure reports
- Expenditure reports not submitted or submitted late
- Inadequate documentation of salaries and benefits
- Modified budget not submitted or submitted late

A Preliminary Review Report identifying proposed findings and recommendations is issued to the district attorney's office and they have 30 calendar days to respond. A Final Review Report is then issued to the district attorney's office and the Insurance Commissioner and they have 30 calendar days to respond. The Final Review Report indicates whether the audit findings are resolved or unresolved at the time the report is released. Unresolved findings may affect future grant distributions to that district attorney's office.

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 2007-08, the Fraud Division's total budget and staffing for maintaining the above programs was **$42,394,991** and **296.0** authorized positions, of which **241.8** personnel years (PY) were expended.

In Fiscal Year 2007-08:

- The Fraud Division maintains ten regional offices statewide serving all 58 counties, of which 35 participated in the Workers' Compensation Insurance Fraud Grant Program. Thirty-four counties participated in the Automobile Insurance Fraud Grant program; nine 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
- Health Fraud Taskforce
- Underground Economy Task Force
- 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 Office 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

APPENDICES

1.) District Attorney Funding for Fiscal Year 2007 – 08
2.) Fraud and Investigation Division Regional Offices and Assigned Counties
3.) Significant Cases (Fiscal Year 2007 – 08)
4.) Suspected Fraudulent Claims (Calendar Years 2006 through 2008)
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6.) Workers Compensation Fraud Convictions (Fiscal Year 2007-08)
7a.) Arrest-Prosecution Summary (Part One)
7b.) Arrest-Prosecution Summary (Part 2)
7c.) Investigations
8a.) Standard Cases in Court
8b.) Medium Cases in Court
8c.) Complex Cases in Court
8d.) Very Complex Cases in Court
8e.) Cases in Court—Prosecuting Caseload
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10.) Press Clippings for Fiscal Year 2007 – 08

Appendix 1: District Attorney Funding for Fiscal Year 2007-08

County	Funding Requested	Funding Awarded	First Distribution	Final Distribution
Alameda	$1,172,936	$1,149,000	$505,560	$643,440
Amador	$495,059	$445,000	$195,800	$249,200
Butte	$195,832	$190,000	$83,600	$106,400
Contra Costa	$505,427	$475,000	$209,000	$266,000
El Dorado	$256,484	$205,000	$90,200	$114,800
Fresno	$1,159,329	$945,000	$415,800	$529,200
Imperial	$93,288	$49,504	$21,782	$27,722
Kern	$460,416	$460,000	$202,400	$257,600
Kings	$273,372	$265,000	$116,600	$148,400
Los Angeles	$4,997,115	$4,899,000	$2,155,560	$2,743,440
Marin	$179,072	$179,072	$78,793	$100,279
Merced	$141,113	$135,000	$59,400	$75,600
Monterey	$268,085	$250,000	$110,000	$140,000
Orange	$3,572,400	$1,850,000	$814,000	$1,036,000
Riverside	$907,701	$906,701	$398,948	$507,753
Sacramento	$878,100	$878,100	$386,364	$491,736
San Bernardino	$1,914,382	$1,899,000	$835,560	$1,063,440
San Diego	$4,589,141	$4,299,000	$1,891,560	$4,299,000
San Francisco	$625,575	$600,000	$264,000	$336,000
San Joaquin	$549,329	$549,329	$241,705	$307,624
San Luis Obispo	$84,776	$80,000	$35,200	$44,800
San Mateo	$634,178	$545,000	$239,800	$305,200
Santa Barbara	$235,159	$235,159	$103,470	$131,689
Santa Clara	$1,606,014	$1,605,014	$706,206	$898,808
Santa Cruz	$56,938	$48,000	$21,120	$26,880
Shasta	$133,044	$133,044	$58,539	$74,505
Siskiyou	$22,490	$18,000	$7,920	$10,080
Solano	$145,435	$145,435	$63,991	$81,444
Sonoma	$178,014	$178,014	$78,326	$99,688
Stanislaus	$321,012	$260,000	$114,400	$145,600
Tulare	$241,327	$241,327	$106,184	$241,327
Tuolumne	$36,249	$20,000	$8,800	$20,000
Ventura	$694,610	$694,610	$305,628	$388,982
Yolo	$167,691	$167,691	$73,784	$93,907
TOTAL	**$27,791,093**	**$25,000,000**	**$8,993,456**	**$16,006,544**

Appendix 2: Fraud and Investigation Division Regional Offices and Assigned Counties

Fraud Division

Name	Address	Counties Served
Headquarters	9342 Tech Center Drive, Suite 100 Sacramento, CA 95826 Phone: (916) 854-5760	All
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

Appendix 2: Fraud and Investigation Division Regional 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

Appendix 3: Significant Cases (Fiscal Year 2007 – 08)

Premium Fraud:

Cover-All, Inc. (05JW009433) – Gad Leshem, Zeev Golan, and Irit Golan, all of Northridge, were each charged, on October 18, 2006, with four counts of premium fraud and one count of conspiracy after an investigation conducted by the California Department of Insurance, Fraud Division (Fraud Division).

Gad Leshem is the president and CEO of Cover-All, Inc., a flooring and carpet installation company headquartered in Chatsworth. Zeev Golan is the vice president and his wife, Irit Golan, is executive secretary and payroll supervisor.

Cover-All obtained a workers' compensation policy from State Compensation Insurance Fund (SCIF) on September 1, 2001. A routine SCIF audit revealed that the payroll reported to SCIF was significantly lower than that reported to the Employment Development Department (EDD). As a result, SCIF referred the case to the Fraud Division.

During the course of the investigation, it was learned that Zeev and Irit Golan were responsible for preparing the alleged fraudulent monthly payroll reports provided to SCIF. The monthly payroll reports were approved by President Gad Leshem. The investigation determined that over a four-year period, Cover-All underreported payroll of $26,937,575 to SCIF. This underreported payroll resulted in a premium loss of $6,300,000.

Prosecuting Authority: Los Angeles County
Fraud Type: Premium Fraud/Underreported Wages
Conviction: On June 2, 2008, Cover-All Inc. pleaded no contest to one count of insurance fraud. Gad Leshem, Cover-All's owner and president, agreed to pay $6,300,000 to the SCIF as part of a plea agreement.

Avoca Trucking and Excavating (AT&E) company (04BW023411) – Martha P. O'Neill, of San Francisco, was arrested on 49 felony counts of alleged workers' compensation insurance premium fraud and employment tax fraud.

O'Neill is the corporate officer of Avoca Trucking and Excavating (AT&E) company. O'Neill was charged with five felony counts of premium fraud; five felony counts of preparing false documents; three felony counts of knowingly providing a forged or fraudulent document; 30 felony counts of employment tax fraud; and four felony counts of taking a portion of workers' wages in connection with a public works project.

According to investigators, O'Neill owned and operated AT&E since 1996 as a general engineering and building contractor. O'Neill worked primarily for the City and County of San Francisco and other Bay Area cities and counties. To do so, she was required to comply with state laws, wage, and union requirements. She employed over 100 employees from January 1, 2001, through June 9, 2005. O'Neill allegedly underreported her employee payroll to SCIF by $2,255,173 and to EDD by $3,160,319. As a result, SCIF was defrauded out of $283,528 in premiums and EDD was defrauded out of $629,235 in payroll taxes.

Prosecuting Authority: San Francisco County
Fraud Type: Premium Fraud/Underreported Wages
Conviction: On September 9, 2008, Martha O'Neill was sentenced to one year in county jail, five years of probation, $500,000 in restitution.

Tapuz Enterprises (01JW000070) – On September 17, 2007, Tomer Rotholz and Yosef Khalib were convicted of defauding insurance compaines by operating two corporations that failed to properly report their employee payrolls.

Rotholz, owner of Tapuz Enterprises, a landscaping and street repair business, had been awarded several public works contracts in the Ventura area when an investigation by the Fraud Division and the Vertura County District Attorney's office revealed Rotholz had intentionally underreported the company's payroll to SCIF. Tapuz was barred from public works projects and had its contractors license suspended.

Tapuz closed operations and Rotholz started a shell corporation, Nativ Engineering, hiring Khalib to operate the day-to-day operations and listing him as owner. The fraud continued under the new company name as the investigation discovered Nativ Engineering was underreporting its payroll as well.

This case was prosecuted by the Ventura County District Attorney's Office.

Prosecuting Authority: Ventura County
Fraud Type: Premium Fraud/Underreported Wages
Conviction: On November 28, 2007, Tomer Rotholz was sentenced to two years in state prison and ordered to pay $130,900 in restitution. Yosef Khatib was sentenced to 36 months of probation and ordered to pay $28,596 in restitution.

Shawn Dodd (03FW018451) – Shawn Dodd, was arrested on January 29, 2007 on four felony counts of insurance fraud, one count of workers' compensation insurance premium fraud, two counts of employer tax evasion, one count of money laundering, and two counts of conspiracy to obtain property under false pretenses.

The Fraud Division, received a Suspected Fraudulent Claim Form (SFC) in November 2003 alleging that Shawn Dodd, owner of a chiropractic and therapy conglomerate consisting of Provident Medical Management Group, Neurosport Chiropractic, Old River Medical Center, and Cal-Sport Physical Therapy, was operating her business without workers' compensation insurance. The SFC went on to say that Dodd was attempting to get an injured employee, Rachel Russell, to accept in-house medical treatment and forestall her workers' compensation claim until Dodd could get a policy in place.

On February 20, 2004, a search warrant was served on Dodd's business and her home in conjunction with the above allegation, as well as a multitude of other business and personal fraudulent insurance practices. Evidence retrieved, following the service of the search warrant and the ensuing investigation, revealed that Shawn Dodd deliberately provided the SCIF with false information regarding the number of employees she had working for her and the amount of her employee payroll, in order to minimize the deposit requirement on her 2000 and 2001 workers' compensation policies. Dodd also provided SCIF with a false employee job classification on her 2003 policy renewal, which resulted in a substantial premium rate reduction and she was responsible for preventing Rachel Russell from filing a timely workers' compensation claim that same year.

Prosecuting Authority: Kern County
Fraud Type: Premium Fraud
Indicted: On February 21, 2008, a Kern County Grand Jury indicted Shawn Dodd on twelve felony charges including premium fraud, embezzlement, and making a false or misleading statement in support of an insurance claim. Ms. Dodd's trial is scheduled to start in August 2008.

Guzman Brothers Farm Labor (05AW008621) **–** Rafael Guzman was arrested on March 14, 2007 and Lourdes Guzman was arrested on May 21, 2007.

The San Joaquin County District Attorney's Office received an anonymous phone call regarding Rafael Guzman, owner of Guzman Brothers Farm Labor. Guzman is a farm labor contractor in San Joaquin County. The caller indicated Guzman was underreporting his payroll. An initial inquiry made by the District Attorney's office indicated that Guzman has contracts with Ronald Nunn and Tamayo Vinyards. A review of the 2001 1099s show Guzman grossed $988,484.00, but only reported $198,665 in wages to the EDD. A review of 2002 1099s show Guzman grossed $1,491,972.00, but only reported $404,761.00 in wages to EDD.

The arrests were a result of a joint investigation by the San Joaquin County District Attorney's Office, the Fraud Division and EDD.

Prosecuting Authority: San Joaquin County
Fraud Type: Premium Fraud
Conviction: On January 31, 2008, Rafael Guzman was sentenced to 16 months in State prison. Lourdes Guzman was sentenced to 12 days in county jail and 5 years of probation. Both defendants were ordered to pay $2,000,000 in restitution and $440 in criminal fines.

Larry Gonzales (06FW001716) – Larry Gonzales, 56, of Bakersfield, was arrested on May 30, 2007 on one felony count of workers' compensation insurance premium fraud and one felony count of insurance fraud.

During a routine audit by SCIF, auditors found that Larry Gonzalez, Farm Labor Contracting, underreported payroll for two policy years by over $2,000,000. EDD confirmed that Gonzalez reported more to EDD than to SCIF. This resulted in a loss of approximately $810,000 to SCIF.

A search warrant was served on Larry Gonzales' business and residence in September 2006. Payroll evidence and other documents were obtained that confirmed Gonzales had underreported his employee payroll by a significant amount. Gonzales confirmed, during an interview, that he underreported his payroll claiming his bookkeeper, Angie Nunez, was filing fictitious paperwork under his direction. Payroll records were obtained from Gonzales' primary employer which shows a large amount of payroll underreporting by Gonzales.

Prosecuting Authority: Kern County
Fraud Type: Premium Fraud/Underreporting Wages
Conviction: On February 13, 2008, Larry Gonzales was sentenced to 90 days in county jail and ordered to pay $785,540 in restitution and $220 in criminal fines.

Out West Construction (00HW000055) – Frank and Rosemary Mitchell, owners of Out West Construction, were arrested on December 21, 2001 on charges of under reporting employee payroll and misclassifying employees.

Prosecuting Authority: San Bernardino County
Fraud Type: Premium Fraud/Underreporting Wages
Conviction: On October 31, 2007, Rosemary Mitchell was sentenced to 365 days in county jail and ordered to pay $1,475,462 in restitution. Frank Mitchell died in May 2004.

PDL Inc. (02HW012210) – On November 15, 2005, Luis Diaz was convicted on one count of workers' compensation insurance premium fraud and one count of grand theft. Diaz failed to disclose the correct number of employees to SCIF and EDD.

Prosecuting Authority: San Bernardino County
Fraud Type: Premium Fraud/Underreporting Wages
Conviction: On April 17, 2008, Luis Diaz was sentenced to 36 months of probation, $90,000 in restitution, and $110 in criminal fines.

Pamela Erb (06BW008261) – On June 6, 2008 Pamela Erb was arrested on 16 counts including premium fraud, failure to secure workers' compensation insurance coverage, and failing to collect unemployment insurance.

Pamela Erb is the owner and operator of Pam's Office Solutions, a modular furniture installation business. Erb reported to SCIF that her employees were independent contractors. Erb also failed to report her employees to EDD. Audits conducted on Erb's payroll records established that Erb misrepresented her employee's positions to SCIF. Interviews of former employees alleged that Erb knowingly and intentionally misrepresented her employees as independent contractors thereby saving her a significant amount of money in premium owed to SCIF. Erb allegedly made the same misrepresentations to Midwest Insurance.

The loss to State Fund for an approximate three-year period was determined to be $157,441. The loss to Midwest Insurance was determined to be approximately $17,384. An audit conducted by EDD determined that Erb owed EDD $157,647.60 in taxes, penalties and interest.

Prosecuting Authority: Alameda County
Fraud Type: Premium Fraud/Underreporting Wages
Status: Pending

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
Status: Pending

San Joaquin Valley Premium Fraud Task Force[7]**:**

Royal Farm LLC (04FW023405) – On March 28, 2008, Kirpal Sihota was convicted on two counts of premium fraud, employee misclassification.

In July 2002, Kirpal Sihota applied for workers' compensation coverage under the name of Royal Farming LLC. The application described a grape farm with 400 acres, with vineyards listed as the only job classification. Sihota had a previous trucking business under Royal Express DBA as DEF Express Inc. The business policy was cancelled without cause and was not renewed under the same owner. In reviewing the injury claims for Royal Farming's 2002 policy year and continuing, SCIF noted that 21 of 27 reported claims were for truck drivers and not employees working in vineyards.

After reviewing the Royal Farming payroll for the 2002/2003 policy year, SCIF found the only payroll classification reported was in vineyards. The payroll and injury claims differ significantly from the business described on Royal Farming's application for insurance.

In May 2008, Kirpal Sihota pled guilty and was ordered to pay 1.8 million and perform community service. This case was investigated by the San Joaquin Valley Premium Fraud Task Force and prosecuted by the Fresno County District Attorney's Office.

Prosecuting Authority: Fresno County
Fraud Type: Premium Fraud/Misclassification
Conviction: On May 8, 2008, Kirpal Sihota was sentenced to 600 hours of community service, five years probation, and ordered to pay $1,800,000 in restitution.

J & R Custom Trim Work (07FW013799) – On June 12, 2008, Javier Flores and Ramon Flores both pled no contest to one count of workers' compensation insurance premium fraud in Tulare County Superior Court.

Tulare County District Attorney's Office reported that they were contacted by a third party regarding J&R Custom Trim working on a public project in Woodlake, paying their employees in cash and not having workers' compensation insurance. An investigation ensued and the case was filed with the Tulare County District Attorney's Office, which issued arrest warrants for Javier and Ramon Flores for premium fraud, conspiracy, and uninsured employer fraud.

This case was investigated by the San Joaquin Valley Premium Fraud Task Force and prosecuted by the Tulare County District Attorney's Office.

[7] *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.*

Prosecuting Authority: Fresno County
Fraud Type: Premium Fraud/Uninsured Employer
Conviction: On June 12, 2008, Javier Flores pled no contest to workers' compensation insurance premium fraud and was sentenced to 90 days County Jail, three years probation, $500 in restitution and $770 in criminal fines. Ramon Flores pled no contest to an uninsured employer count and was sentenced to 30 days county jail, three years probation, and $260 on criminal fines.

Medical Provider*:*

Accident Help Line (03FW003701) – Charles Affatato, Marisela Montes, Elizabeth Rodriguez, William Sheaffer, Jason Walker, Lorene Hebert, Ralph Howell, Mark Lungren, Mikel Meyer, Eva Prieto, Ronald Richards and Emma Mendez Defarless were administratively re-arrested in November 2007, 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.

Ramon Reynoso (03BW004909) – Chiropractor Ramon Reynoso, arrested on October 30, 2006, is suspected of billing insurance carriers for the use of certified interpreters when non-certified interpreters were used during qualified medical examinations of Spanish speaking claimants. Reynoso is fluent in Spanish and may not have used an interpreter at all and still may have billed for the use of one.

On October 30, 2006, a federal grand jury indicted Reynoso for income tax evasion of more the $3.6 million dollars.

This was a joint investigation of the Fraud Division and the Internal Revenue Service.

Prosecuting Authority: US Attorney Northern District
Fraud Type: Medical Provider
Conviction: On September 12, 2007 Ramon Reynoso was convicted of one count of tax evasion and was ordered to pay $1,162,222 in restitution.

Shane Whiteley (07AW016468) – 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. He was sentenced to three years probation and $1,181 in restitution and $3,332 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 SIU 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: Solano 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. He was sentenced to three years probation and $1,181 in restitution and $3,332 in criminal fines.

Dr. Jay Vogel (04BW015752) – On May 29, 2008, Dr. Jay Vogel was arrested in Orange County on an Alameda County warrant alleging 40 instances of felony insurance fraud. Dr. Vogel was held in lieu of $680,000 bail at the time of the arrest.

The Fraud Division was alerted to this case by another physician who had examined several of Dr. Vogel's patients, reviewed their medical records, and determined there were irregularities in the treatments and services being provided. The investigation revealed allegations of billing for services not rendered, unnecessary interpreters services, and prescribing medical equipment that was not necessary. The amount of alleged fraud in this case is approximately $1,000,000.

Prosecuting Authority: Alameda County
Fraud Type: Medical Provider
Status: Pending

<u>Employer Defrauding Employee:</u>

Bel Air Roseville (07AW005191) – On December 12, 2007, Bel Air Market Store Director Nichole Leddy and Assistant Store Director Amy Looper each pleaded no contest to one count of workers' compensation insurance fraud.

A CDI investigation revealed that Leddy and Looper discouraged several injured employees at Bel Air Market from filing workers' compensation claims in order to keep the store record injury-free and earn special store incentives, including barbecues and bonuses for management. Employees were instructed to seek treatment through individual health insurance polices and in some instances, tell their private physician the work-related injuries happened at home. When interviewed, Leddy and Looper both made admissions regarding discouraging employees from filing workers' compensation claims.

This case was a joint investigation between the Fraud Division and the Amador County District Attorney's Office. The case was prosecuted by the Placer County District Attorney's Office.

Prosecuting Authority: Placer County
Fraud Type: Employer Defrauding Employee
Conviction: On December 11, 2007, Nichole Leddy was sentenced to 360 hours of community service, three years of probation, and ordered to pay $13,500 in restitution. Amy Looper was sentenced to 360 hours of community service, three years of probation and $2,500 in restitution.

Western Tree Service (05HW010418) – On April 19, 2007 Matthew Day was convicted of one count of workers' compensation insurance fraud.

Matthew Day, owner of Western Tree Service, reported to the Department of Insurance that Carlos Jaramillo was attempting to make a workers' compensation claim against his company. Day said he never hired Jaramillo, but Jaramillo was claiming to be injured while working for him. The investigation showed Day hired Jaramillo, prior to Jaramillo being injured.

Prosecuting Authority: San Bernardino County
Fraud Type: Employer Defrauding Employee
Conviction: On April 1, 2008, Matthew Day was sentenced to One day in county jail, three years of probation, and ordered to pay $74,477 in restitution.

SW Gill (04DW021384) – On June 19, 2006, contractor Steven Gill, owner of SW Gill Painting, was convicted on one count of workers' compensation insurance premium fraud. Steven Gill denied workers' compensation benefits to his employees.

Prosecuting Authority: Orange County
Fraud Type: Employer Defrauding Employee
Conviction: Steven Gill was sentenced to three years in state prison, five years of probation, $62,070 restitution, and $20,220 in criminal fines.

Smurfit-Stone (06GW022845) – Douglas Tateoka, Superintendent and David Polk, retired human resources manager of Smurfit-Stone Container Enterprises and Dr. Eugene Guzman of Pinnacles Urgent Care were arrested on October 31, 2007 for insurance fraud and conspiracy.

On October 6, 2006, an employee of Smurfit Stone Container Corporation contacted the Monterey District Attorney's Office stating the company is dissuading employees from reporting work related injuries and paying incentives for not reporting claims. The employee stated the company's practice is to take injured employees to see Dr. Guzman. Once at the clinic, the employees are directed not to disclose that the injury is work related. Prescription medications are issued to the management personnel, not to the injured workers.

The Monterey County District Attorney's Office received a second call from another employee of Smurfit Stone providing the same information but added he believed that David Polk, the Human Resources Manager and Doug Tateoka have orchestrated a plan to minimize the company's insurance premiums by not reporting employees as well as the workers' compensation claims. The employees stated there have allegedly been some instances where Polk and Tateoka have visited the injured employees at their homes to "talk" about not reporting the injuries.

Monterey County District Attorney's Office initiated this investigation and is prosecuting this case.

Prosecuting Authority: Monterey County
Fraud Type: Employer Defrauding Employee
Status: Pending

Claimant Fraud:

June Ann Lucena (04AW007685) – June Lucena, a former correctional officer, was convicted on December 4, 2007 of 14 counts of workers' compensation insurance fraud, perjury, and grand theft. This case was one of the first in which a disability pension investigation led to criminal charges.

On April 4, 2004, the Fraud Division was contacted regarding possible insurance fraud committed by June Lucena. Lucena was a correctional officer with the California Department of Corrections and Rehabilitation when she claimed she had fallen from a guard tower at Folsom State Prison and sustained injuries. Lucena had complained to various doctors about having constant pain and being unable to perform certain physical activities. Lucena also stated that she was unable to perform physical activities like riding jet skis, riding water slides, and was only able to eat soft foods. An investigation revealed Lucena's statements in her deposition and to doctors were contradicted by surveillance video, which revealed Lucena riding jet skis, riding water slides, and performing physical activities, which she told doctors she was unable to perform.

This case was prosecuted by the Sacramento County District Attorney's Office.

Prosecuting Authority: Sacramento County
Fraud Type: Claimant Fraud
Conviction: On August 22, 2008, June Ann Lucena was sentenced to seven years in state prison and ordered to pay $340,000 in restitution.

Manuel Carreon (04HW024115) – On August 14, 2007, Manuel Carreon of Pomona was convicted of one felony count of workers' compensation insurance fraud following an investigation by Fraud Division investigators.

In 2003, Carreon reported he had strained his back working as a nursing assistant. He was placed on total disability and received benefits. In 2004, Carreon sought employment, and was hired as a carpenter while receiving temporary total disability. Shortly after being hired, Carreon was examined by his physician, denied working, and was continued on temporary total disability. Hartford Casualty Insurance Company lost more than $100,000 in medical, legal, and investigative costs.

Prosecuting Authority: Riverside County
Fraud Type: Claimant Fraud
Conviction: On August 17, 2008, Manuel Carreon was sentenced to two years in state prison and ordered to pay $220 in criminal fines.

Alexander Bourdaniotis (07AW007545) – On March 11, 2008, Alexander Bourdaniotis, a youth correctional counselor at the Division of Juvenile Justice, (formerly the California Youth Authority) was arrested on six felony charges related to workers' compensation insurance fraud, allegedly defrauding the State of more than $150,000.

On November 6, 2005, Bourdaniotis was allegedly assaulted by a youth inmate at the Preston Youth Correctional Facility. After being treated and relieved of his shift that day, Bourdaniotis purportedly drove himself 40 miles home despite subsequently telling doctors his injuries were so severe, he could not drive himself home. Due to his alleged injuries, Bourdaniotis was relieved of duty and never returned to work applying for Industrial Disability Retirement because of the assault. While collecting disability payments, Bourdaniotis applied and passed exams for two professional licenses, despite claiming cognitive injuries.

This case is the result of a six-month joint investigation by the Fraud Division, and the California Department of Corrections and Rehabilitation Office of Internal Affairs' Workers' Compensation Fraud High Impact Team. This case is being prosecuted by the Sacramento County District Attorney's Office

Prosecuting Authority: Sacramento County
Fraud Type: Claimant Fraud
Status: Pending

Stephanie Sargiotto (06BW019697) – On March 17, 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 Department of Insurance Investigators when he reported that he worked for Erb for fourteen months and that Stephanie 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
Status: Pending

Broker/Agent Fraud*:*

Basilio Reyes Jr. – On July 10, 2008, Basilio Reyes Jr., a former insurance agent, was sentenced to seven years in state prison and ordered to pay $646,458 in restitution to his victims.

An Investigation by the California Department of Insurance Investigation Division revealed that during a four-year period from 2002 to 2006, Reyes sold phony commercial liability and workers' compensation polices to small businesses, including a number of nursing and assisted living facilities. In failing to remit premium payments issued to him, Reyes not only stole from his clients, but also exposed them to the danger of potential uninsured losses.

Prosecuting Authority: Los Angeles County
Fraud Type: Broker/Agent Fraud
Conviction: Basilio Reyes Jr. was sentenced to seven years in State prison and ordered to pay $646,458 in restitution

Mindy Elizabeth Latorre – On August 11, 2007, former insurance broker Mindy Latorre was charged with 58 felony counts including insurance fraud, grand theft, and forgery. Later, in November 2007, an additional 115 felony counts were filed in a second criminal complaint filed by Placer County. Charges included insurance fraud, theft of insurance funds, and forgery.

Between April 2003 and June 2006, Latorre collected more than $116,000 in insurance premiums from her clients and diverted the funds for her personal use. According to an investigation conducted by the California Department of Insurance Investigation Division, the funds were to be used for the placement of commercial general liability, commercial property, workers' compensation, and commercial automobile insurance. Latorre also allegedly issued fraudulent certificates of insurance to her clients indicating they had legitimate insurance coverage

Prosecuting Authority: Placer County
Fraud Type: Broker/Agent Fraud
Conviction: On March 13, 2008, Mindy Latorre was sentenced to three years and eight months in state prison and ordered to pay restitution to her victims**.**

Anthony Medina – Anthony Medina was arrested on April 23, 2008 and charged with 153 felony counts including 33 counts of transacting as an insurance company without a certificate of authority and two counts of insurance fraud.

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
Status: Pending

Jay Chang Yeom – On December 21, 2007, Jay Chang Yeom was arrested by investigators of the CDI Investigation Division and charged with 12 felony counts including four counts of insurance fraud.

According to investigators, in 2005 and 2006, the CDI received three complaints alleging that Yeom, dba Komerica Insurance Marketing in Norwalk, had committed theft of premium payments. The initial complaint came from an insurance broker stating that Yeom sent several workers' compensation policy checks for his clients, which were returned by the bank for insufficient funds. The amount of the dishonored checks totaled over $5,300. Other complaints were submitted from business owners stating that they had paid premiums to Yeom in 2004 and 2005 for workers' compensation policies that were never provided.

The investigation revealed that Yeom had collected nearly $23,000 in premiums from seven business owners for workers' compensation policies and had failed to secure the policies with any insurance company. Yeom's actions exposed these business owners to substantial financial loss.

Prosecuting Authority: Los Angeles County
Fraud Type: Broker/Agent Fraud
Status: Pending

Appendix # 4: Suspected Fraudulent Claims (SFCs) (Calendar Years 2006 through 2008)

County	2006 SFCs	2007 SFCs	2008 SFCs	TOTAL
Alameda	322	240	211	773
Alpine	1	1	0	2
Amador	5	7	4	16
Butte	27	12	19	58
Calaveras	14	7	6	27
Colusa	5	1	2	8
Contra Costa	160	159	104	423
Del Norte	2	4	2	8
El Dorado	22	21	15	58
Fresno	153	149	86	388
Glenn	2	4	5	11
Humboldt	11	7	11	29
Imperial	27	17	19	63
Inyo	3	3	3	9
Kern	95	116	59	270
Kings	17	18	17	52
Lake	10	5	8	23
Lassen	9	5	2	16
Los Angeles	1,545	1,772	1,777	5,094
Madera	17	21	20	58
Marin	41	22	25	88
Mariposa	1	0	2	3
Mendocino	10	12	14	36
Merced	34	28	20	82
Modoc	0	0	2	2
Mono	2	1	0	3
Monterey	76	98	55	229
Napa	12	19	24	55
Nevada	9	9	8	26
Orange	452	404	527	1,383
Placer	35	54	46	135
Plumas	0	4	4	8

Appendix # 4: Suspected Fraudulent Claims (SFCs) (Calendar Years 2006 through 2008) (continued)

County	2006 SFCs	2007 SFCs	2008 SFCs	TOTAL
Riverside	399	275	247	921
Sacramento	216	168	127	511
San Benito	8	8	5	21
San Bernardino	311	324	305	940
San Diego	395	401	383	1,179
San Francisco	120	121	115	356
San Joaquin	95	79	62	236
San Luis Obispo	32	25	27	84
San Mateo	99	99	80	278
Santa Barbara	66	43	50	159
Santa Clara	192	290	182	664
Santa Cruz	45	44	28	117
Shasta	38	36	41	115
Sierra	0	0	0	0
Siskiyou	1	3	6	10
Solano	65	56	51	172
Sonoma	67	84	61	212
Stanilaus	70	56	55	181
Sutter	16	13	6	35
Tehama	1	2	3	6
Trinity	1	1	0	2
Tulare	76	58	39	173
Toulumne	6	3	4	13
Ventura	112	105	105	322
Yolo	32	31	29	92
Yuba	7	4	5	16
TOTAL	5,589	5,549	5,113	16,251

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08)

July 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Fresno	07FW010608	Aragon, Ruben	07/06/07	Kings
Benicia	07BW009462	Brabetz, Diane	07/19/07	Sonoma
Sacramento	07AW011795	Digiacinto, Marco	07/26/07	El Dorado
Sacramento	07AW011795	Durrer, Theodore	07/26/07	El Dorado
Benicia	07BW006741	Gallego, Rudy	07/11/07	Contra Costa
Sacramento	07AW011795	Gonzales-Cruz, Hector	07/26/07	El Dorado
Sacramento	05AW022226	Hinton, John	07/09/07	Sacramento
Sacramento	07AW011795	Killion, Steven	07/04/07	El Dorado
Sacramento	07AW011795	Kim, Kurt	07/04/07	El Dorado
Sacramento	05AW019117	Kugel, Kenneth	07/03/07	Sacramento
Benicia	07BW009907	Latu, Vitolio	07/31/07	Contra Costa
Sacramento	07AW011795	Lilley, Daniel	07/26/07	El Dorado
Sacramento	07AW011795	Lopez Gomez, Juan	07/26/07	El Dorado
Inland Empire	07HW000097	Lopez, Irene	07/31/07	San Bernardino
Sacramento	07AW011795	Meadows, Troy	07/04/07	El Dorado
Sacramento	05AW019117	Meienburg, David	07/03/07	Sacramento
So. LA County	06CW009239	Negrete, Robert	07/19/07	Los Angeles
Valencia	07JW002373	Nguyen, Thanh	07/31/07	Los Angeles
Fresno	07FW010608	Numi, Gameel	07/06/07	Kings
Sacramento	06AW012339	Pillay, Lao	07/15/07	Sacramento
Sacramento	07AW011795	Rossier, Chase	07/04/07	El Dorado
Sacramento	07AW011795	Rue, Donald	07/26/07	El Dorado
Benicia	07BW006740	Sau, Samiuela	07/11/07	Contra Costa
Silicon Valley	07GW008214	Serratos, Fernando	07/13/07	Monterey
Benicia	07BW006742	Tamayo, Juan	07/06/07	Contra Costa
Sacramento	07AW011795	Tanner, William	07/04/07	El Dorado
Benicia	07BW009905	Vaea, Siale	07/06/07	Contra Costa
Benicia	07BW009909	Vo, Thua	07/31/07	Contra Costa

August 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Sacramento	06AW006905	Aguilar, Octavio	08/02/07	San Joaquin
Fresno	04FW023405	Alcaraz, Albert	08/14/07	Fresno
Benicia	07BW009463	Allen, Gail	08/15/07	Sonoma
Silicon Valley	07GW016046	Bourgeois, Jack	08/14/07	Santa Cruz
Sacramento	07AW003842	Carlile, Matthew	08/16/07	El Dorado
Silicon Valley	07GW016056	Chikes, Stephen	08/15/07	Santa Cruz
Sacramento	06AW010595	Clayton, Preston	08/06/07	Sutter
Sacramento	07AW000026	Demoss, Dylan	08/14/07	Placer
Fresno	07FW006511	Gabler, Elliott	08/28/07	San Luis Obispo
Benicia	07BW005550	Guzman, Miguel	08/23/07	Contra Costa
Silicon Valley	07GW016064	Kennedy, Timothy	08/15/07	Santa Cruz
Benicia	07BW009465	Khoury, Jalil	08/15/07	Sonoma
Silicon Valley	07GW016050	Laurie-Bartz, Jon	08/14/07	Santa Cruz

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

August 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Sacramento	07AW005191	Leddy, Nichole	08/14/07	Placer
Sacramento	07AW005191	Looper, Amy	08/14/07	Placer
Benicia	07BW009466	Luong, Diep	08/15/07	Sonoma
Benicia	07BW009471	Mattison, Emily	08/15/07	Sonoma
Sacramento	07AW003842	Mccallen, Hiedi	08/24/07	El Dorado
Silicon Valley	07GW016048	Morriss, Ronald	08/14/07	Santa Cruz
Silicon Valley	07GW016068	Mumm, Jr., Edmond	08/15/07	Santa Cruz
Fresno	04FW023405	Randalls, Sandra	08/14/07	Fresno
Fresno	04FW007741	Salter, Linda	08/23/07	Madera
Sacramento	06AW014356	Sanghera, Rajinder	08/13/07	Colusa
Fresno	04FW023405	Sihota, Kirpal	08/14/07	Fresno
Benicia	06BW017948	Sio, Tatafu	08/07/07	Contra Costa
Fresno	04FW023405	Sosa, Cynthia	08/14/07	Fresno
Silicon Valley	07GW016049	Turner, Harold	08/14/07	Santa Cruz
Silicon Valley	07GW016060	Villanueva, Agustin	08/15/07	Santa Cruz
Silicon Valley	07GW016066	Zambrano, Jose	08/15/07	Santa Cruz

September 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Sacramento	07AW017149	Abizdris, Gilad	09/26/07	Yolo
Benicia	07BW017073	Alterio, Gaetano	09/25/07	Solano
Sacramento	07AW017149	Anderson, Calvin	09/26/07	Yolo
Valencia	03JW012296	Anderson, Norman	09/07/07	Ventura
Benicia	07BW017073	Andujo, Jaime	09/25/07	Solano
Benicia	07BW017073	Arana, Ivan	09/25/07	Solano
Valencia	07JW007423	Bakhyt, Said	09/26/07	Los Angeles
Silicon Valley	07GW016105	Baze Jr., Donald	09/06/07	Monterey
Benicia	07BW012273	Bergeron, Morris	09/05/07	Alameda
Silicon Valley	07GW016076	Bowers, Dwayne	09/06/07	Monterey
Sacramento	07AW006095	Burlew, Robin	09/19/07	Siskiyou
Silicon Valley	07GW016091	Cabaccang, Mario	09/06/07	Monterey
Inland Empire	06HW012491	Defever Aguilar Pioquint, Betty	09/25/07	San Bernardino
Benicia	07BW017364	Delgado, Juan	09/25/07	Solano
Sacramento	07AW017149	Diaz, Alexandro	09/26/07	Yolo
Sacramento	06AW014325	Gaton, Karen	09/07/07	Placer
Silicon Valley	07GW016123	Giron, Rick	09/06/07	Monterey
Benicia	07BW009470	Heaney, Jessica	09/04/07	Sonoma
Sacramento	07AW017149	Hernandez, Antonio	09/26/07	Yolo
Benicia	07BW017073	Hernandez, Pedro	09/25/07	Solano
Sacramento	07AW009956	Ho, Hai	09/19/07	Sacramento
Silicon Valley	07GW016122	Hoagland, James	09/06/07	Monterey
Silicon Valley	07GW016119	Holmes, David	09/06/07	Monterey
Silicon Valley	07GW016101	Jimenez, Adan	09/06/07	Monterey

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

September 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Benicia	07BW016722	Kershaw, Alexander	09/17/07	Contra Costa
Sacramento	07AW017149	Lavalley, Joseph	09/26/07	Yolo
Benicia	07BW017364	Legorreta, Senovio	09/25/07	Solano
Benicia	07BW017073	Leireyma, Juan	09/25/07	Solano
Benicia	07BW017073	Loar, William	09/25/07	Solano
Sacramento	07AW017149	Lobao, David	09/26/07	Yolo
Benicia	07BW017073	Lorenzana, Raul	09/25/07	Solano
Sacramento	07AW017149	Lynch, John	09/27/07	Yolo
Benicia	07BW017073	Martin, Steve	09/25/07	Solano
Sacramento	07AW009956	Medina, Benjamin	09/19/07	Sacramento
Silicon Valley	07GW016121	Mehlert, Robert	09/06/07	Monterey
Sacramento	07AW017149	Milton, Zeodolion	09/26/07	Yolo
Sacramento	07AW017149	Mora, Alejandro	09/26/07	Yolo
Silicon Valley	07GW016097	Nicolas, Enrique	09/06/07	Monterey
Silicon Valley	07GW016088	Nilsen, Philip	09/06/07	Monterey
Sacramento	07AW017149	Ohomana, Taukei	09/26/07	Yolo
Benicia	07BW017073	Ortega, J	09/25/07	Solano
Benicia	07BW012273	Owens, Joanna	09/05/07	Alameda
Sacramento	07AW017149	Perez, Graciano	09/27/07	Yolo
Silicon Valley	07GW016109	Pool, Randall	09/06/07	Monterey
So. LA County	06CW012207	Rendon, Bertha	09/27/07	Los Angeles
Silicon Valley	07GW016115	Resendiz Nieto, J	09/06/07	Monterey
Benicia	07BW017073	Reyes, Antonio	09/25/07	Solano
Sacramento	07AW017149	Reyes, Santos	09/27/07	Yolo
Sacramento	07AW017149	Rogers, Floyd	09/26/07	Yolo
Silicon Valley	07GW016093	Rubio, Arnulfo	09/06/07	Monterey
Benicia	07BW012273	Sams, Michelle	09/05/07	Alameda
San Diego	06EW014703	Sanchez, America	09/25/07	San Diego
Sacramento	07AW009956	Sarguis, Victor	09/19/07	Sacramento
Silicon Valley	07GW016085	Taddeo, Vincent	09/06/07	Monterey
Benicia	07BW017073	Tapia, Braulio	09/25/07	Solano
Benicia	07BW017073	Trujillo, Jose	09/25/07	Solano
Benicia	07BW017073	Truong, Bang	09/25/07	Solano
Sacramento	07AW009956	Turknett, Kenneth	09/19/07	Sacramento
Benicia	07BW002287	Viray, Aristole Deleon	09/04/07	Alameda
Sacramento	07AW017149	Waldrum, Sharif	09/26/07	Yolo
Sacramento	07AW017149	Watkins, Eric	09/26/07	Yolo
Sacramento	07AW017149	Wharton, Simon	09/27/07	Yolo
Sacramento	07AW017149	Wharton, William	09/27/07	Yolo
Benicia	07BW017073	Zambrano, Alvaro	09/25/07	Solano

October 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Benicia	07BW013111	Ayala, Marcelino	10/16/07	Contra Costa

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

October 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Silicon Valley	07GW020075	Bodily, Brent	10/11/07	Santa Clara
Benicia	07BW009468	Brooks, Stephen	10/11/07	Sonoma
Benicia	07BW009475	Bynum, Ngamnit	10/11/07	Sonoma
Valencia	06JW018737	Catalano, Eloise	10/24/07	Los Angeles
Inland Empire	06HW018137	Cielo, Jose	10/18/07	Riverside
Benicia	07BW017700	Dang, Be	10/24/07	Contra Costa
Benicia	04BW023181	Engberson, Donald	10/05/07	Contra Costa
Benicia	07BW008452	Gonzalez, Jose	10/02/07	Alameda
Silicon Valley	06GW022845	Guzman Jr., Eugene	10/31/07	Monterey
Silicon Valley	07GW020078	Hart, Rupert	10/12/07	Santa Clara
Benicia	06BW004318	Howard, Wendi	10/02/07	Alameda
Silicon Valley	07GW020059	Huerta, Jorge	10/11/07	Santa Clara
Benicia	06BW019424	Inocencio, Daniel	10/19/07	Santa Clara
Benicia	06BW013689	James, Claude	10/24/07	Alameda
Benicia	07BW009473	Kan, Hyuk	10/11/07	Sonoma
Sacramento	07AW009956	Khan, Rafi	10/22/07	Sacramento
Silicon Valley	07GW020063	Mitchell, Johanne	10/11/07	Santa Clara
Silicon Valley	07GW020061	Munoz, German	10/11/07	Santa Clara
Silicon Valley	07GW020072	Navallez, Al	10/11/07	Santa Clara
Silicon Valley	07GW020064	Patterson, Robert	10/11/07	Santa Clara
Silicon Valley	07GW020057	Pena Sr., James	10/11/07	Santa Clara
Silicon Valley	06GW022845	Polk, David	10/31/07	Monterey
Silicon Valley	07GW020060	Rivera, Ezequiel	10/11/07	Santa Clara
Inland Empire	07HW011114	Saltsman, William	10/22/07	San Bernardino
Silicon Valley	07GW020073	Sanchez, Pablo	10/11/07	Santa Clara
Silicon Valley	07GW020066	Santiago, Ramiro	10/11/07	Santa Clara
Orange	06DW019760	Sudbeck, Trent	10/05/07	Orange
Silicon Valley	06GW022845	Tateoka, Douglas	10/31/07	Monterey
Silicon Valley	07GW020068	Tonna, Robert	10/11/07	Santa Clara
Silicon Valley	07GW020055	Tran, Tam	10/11/07	Santa Clara
Benicia	07BW005289	Truong, Thomas	10/22/07	Contra Costa
Valencia	04JW017515	Tullio, Dena	10/09/07	Los Angeles
Valencia	06JW002605	Vilanova, Oscar	10/10/07	Los Angeles
Silicon Valley	07GW020076	Westbrook, Stuart	10/12/07	Santa Clara

November 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Fresno	03FW003701	Affatato, Charles	11/28/07	Merced
Orange	03DW008647	Fuentes, Odir	11/10/07	Orange
Benicia	07BW021185	Gonzales, Adrian	11/15/07	Alameda
Fresno	03FW003701	Hebert, Lorene	11/28/07	Merced
Fresno	03FW003701	Howell, Ralph	11/28/07	Merced
Valencia	07JW011816	Lepe, Jorge	11/27/07	Los Angeles

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

November 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Fresno	03FW003701	Lungren, Mark	11/28/07	Merced
So. LA County	06CW014507	Mansury, Toba	11/28/07	Los Angeles
Inland Empire	07HW010299	Marquez, Jose	11/12/07	Riverside
Fresno	03FW003701	Mendez Defarless, Emma	11/28/07	Merced
Fresno	03FW003701	Meyer, Mikel	11/28/07	Merced
Benicia	05BW012952	Minks, Myra	11/28/07	San Francisco
Valencia	07JW010907	Mkrtchian, Gayane	11/13/07	Los Angeles
Fresno	03FW003701	Montes, Marisela	11/28/07	Merced
Fresno	03FW003701	Prieto, Eva	11/28/07	Merced
Sacramento	07AW009956	Razumovsky, Sergey	11/30/07	Sacramento
Sacramento	07AW009956	Razumovsky, Slava	11/30/07	Sacramento
Fresno	03FW003701	Richards, Ronald	11/28/07	Merced
Fresno	03FW003701	Rodriguez, Elizabeth	11/28/07	Merced
Valencia	06JW022706	Sanchez, Florinda	11/19/07	Ventura
Sacramento	07AW020739	Sang, Richard	11/30/07	San Joaquin
Benicia	07BW009472	Shaw, Sanjib	11/06/07	Sonoma
Fresno	03FW003701	Sheaffer, William	11/28/07	Merced
Fresno	03FW003701	Walker, Jason	11/28/07	Merced

December 2007

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Benicia	07BW009464	Anderson, Richard	12/03/07	Sonoma
Fresno	07FW022377	Kaur, Amarjit	12/19/07	Kern
Sacramento	07AW020739	Lao, Amber	12/03/07	San Joaquin
Fresno	07FW022377	Lehmkuhl, David	12/19/07	Kern
Benicia	05BW022143	Moore, Sharon	12/12/07	San Francisco
So. LA County	07CW004527	Oandasan, Dexx	12/19/07	Los Angeles
Valencia	07JW018205	Rivas, James	12/20/07	Los Angeles
Sacramento	07AW020739	Sang, Brookes	12/03/07	San Joaquin
Fresno	07FW022377	Singh, Simbal	12/19/07	Kern
Sacramento	07AW020177	Soderquist, James	12/17/07	Sacramento
Benicia	07BW010810	Tausch, Lawrence	12/03/07	Sonoma
San Diego	07EW000210	Watson, Michael	12/11/07	San Diego
Sacramento	07AW016468	Whiteley, Shane	12/10/07	Solano
Sacramento	07AW012162	Winner, Sharon	12/20/07	Sacramento

January 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Sacramento	07AW009956	Afagh, Bahram	01/11/08	Sacramento
Sacramento	07AW021891	Barboza, Armondo	01/29/08	Sacramento
So. LA County	06CW019907	Basurto-Aguirre, Daniel	01/09/08	Los Angeles
Sacramento	07AW020028	Bhamani, Akbar	01/07/08	Sacramento

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

January 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Sacramento	04AW016940	Cortez, Salvador	01/02/08	Sacramento
Inland Empire	07HW011544	Flores, Lizeth	01/10/08	Los Angeles
So. LA County	06CW004279	Luzcarmonas, Jorge	01/10/08	Los Angeles
Benicia	07BW001651	Reyes, Eugenia	01/15/08	Solano
Fresno	07FW022377	Sanchez, Steven	01/16/08	Kern
Sacramento	05AW008661	Temple, Dolinda	01/03/08	Sacramento
Sacramento	07AW011795	Thiel, John	01/22/08	El Dorado

February 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Sacramento	08AW001153	Avila, Jose R	02/14/08	Yolo
Inland Empire	07HW012796	Barajas, Octavio	02/27/08	San Bernardino
Inland Empire	07HW000842	Barsz, Ronald	02/28/08	San Bernardino
Fresno	07FW006436	Cruz-Colores, Francisco	02/05/08	Fresno
Sacramento	08AW001153	Esquivel, Juan	02/14/08	Yolo
Fresno	07FW013799	Flores, Javier	02/15/08	Tulare
Sacramento	08AW001153	Flores, Oscar	02/14/08	Yolo
Fresno	07FW013799	Flores, Ramon	02/15/08	Tulare
Sacramento	08AW001153	Garcia, Alejandro	02/14/08	Yolo
Sacramento	08AW001153	Irichek, Demyan	02/14/08	Yolo
Benicia	07BW011301	Khashabi, Avissa	02/04/08	Contra Costa
Inland Empire	07HW011771	Kim, Seoung	02/21/08	San Bernardino
Benicia	04BW010896	Lefort, Saul	02/12/08	Mendocino
Sacramento	08AW001153	Lopez, Pedro	02/14/08	Yolo
Sacramento	08AW001153	Madera, Nicolas	02/14/08	Yolo
Sacramento	08AW001153	Madera, Ruben	02/14/08	Yolo
Sacramento	08AW001153	Mariscal, Diego	02/14/08	Yolo
Sacramento	08AW001153	Mondragon, Miguel A	02/14/08	Yolo
Benicia	07BW011298	Morales, Rosa	02/04/08	Contra Costa
Sacramento	05AW004213	Paul, Kellie	02/15/08	San Joaquin
San Diego	04EW006896	Philibert, Emmanuelle	02/05/08	San Diego
Sacramento	08AW001153	Sievers, Edward	02/14/08	Yolo
Sacramento	08AW001153	Silva, Miguel Angel	02/14/08	Yolo
Inland Empire	07HW021598	Tegge, Scott	02/27/08	San Bernardino
Inland Empire	07HW011776	Tran, Lani	02/14/08	San Bernardino
Sacramento	08AW001153	Vega, Richard	02/14/08	Yolo

March 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Benicia	08BW004289	Aguilar, Antonio	03/12/08	Napa
San Diego	07EW007187	Aguirre, Javier	03/13/08	San Diego
So. LA County	07CW006842	Ahumada, Maria	03/18/08	Los Angeles

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

March 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
San Diego	07EW007187	Aquilar, Ricardo	03/12/08	San Diego
Sacramento	08AW003585	Baker, Charles	03/13/08	El Dorado
Sacramento	08AW003585	Balderston, Ronald	03/13/08	El Dorado
San Diego	07EW007187	Bonito, Robert	03/12/08	San Diego
Sacramento	07AW007545	Bourdaniotis, Alexander	03/11/08	Sacramento
Sacramento	08AW003585	Briggs, Larry	03/12/08	El Dorado
Benicia	08BW004289	Brooks, Thomas	03/12/08	Napa
San Diego	07EW007187	Brown, Louis	03/13/08	San Diego
Sacramento	08AW003585	Broyles, Kelly	03/13/08	El Dorado
San Diego	07EW007187	Chavez, Joel	03/12/08	San Diego
Benicia	08BW004289	Collier, Jr., Harry	03/13/08	Napa
Benicia	08BW004289	Conley, James	03/13/08	Napa
San Diego	07EW007187	Cook, Donald	03/13/08	San Diego
Benicia	07BW002597	Cook, Gregory	03/17/08	Sonoma
San Diego	07EW007187	Cubbison, Paul	03/13/08	San Diego
Benicia	04BW000189	Deleon, Erick	03/20/08	Contra Costa
San Diego	07EW007187	Diaz, David	03/12/08	San Diego
So. LA County	07CW013622	Dixon, Richard	03/12/08	Los Angeles
San Diego	07EW007187	Doe, Timothy	03/12/08	San Diego
Benicia	08BW004289	Doria, Georgina	03/12/08	Napa
San Diego	07EW007187	Dovganyuk, Ruslan	03/13/08	San Diego
Benicia	08BW004289	Duenas, Angel	03/12/08	Napa
Silicon Valley	07GW000493	Duong, Douglas	03/25/08	Santa Clara
Benicia	08BW004289	Esquivel, Enrique	03/12/08	Napa
Benicia	07BW014147	Fisiiahi, Suli	03/13/08	Contra Costa
Sacramento	08AW003585	Forrester, Larry	03/12/08	El Dorado
San Diego	07EW007187	Garcia, Jose	03/13/08	San Diego
San Diego	07EW007187	Garcia, Mark	03/12/08	San Diego
Benicia	08BW004289	Garrido, Daniel	03/13/08	Napa
San Diego	07EW007187	Garrison, Ty	03/12/08	San Diego
Inland Empire	07HW011546	Gomez, Roxana	03/06/08	Los Angeles
San Diego	07EW007187	Gonzalez, Albert	03/12/08	San Diego
San Diego	07EW007187	Gonzalez, Gary	03/12/08	San Diego
Benicia	08BW004289	Gonzalez-Medina, Ignacio	03/13/08	Napa
San Diego	07EW007187	Gutierrez, George	03/12/08	San Diego
Silicon Valley	07GW000493	Ha, Bao	03/25/08	Santa Clara
Benicia	08BW004289	Hammond, James	03/12/08	Napa
So. LA County	06CW018117	Hampton, Jeffrey	03/06/08	Los Angeles
Benicia	08BW004289	Hurley, Michael	03/12/08	Napa
Silicon Valley	07GW000493	Huynh, Natalie	03/25/08	Santa Clara
San Diego	07EW007187	Jacobs, Randy	03/12/08	San Diego
Inland Empire	06HW013600	Johnson, Chad	03/19/08	Riverside
San Diego	07EW007187	Jones, Timothy	03/12/08	San Diego

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

March 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
San Diego	07EW007187	Larrazabal, Juan	03/12/08	San Diego
Sacramento	08AW003585	Loera, Jesus	03/12/08	El Dorado
Sacramento	08AW003585	Magana, Humberto	03/13/08	El Dorado
Benicia	08BW004289	Maldanado, Raynaldo	03/12/08	Napa
San Diego	07EW007187	Mata, James	03/13/08	San Diego
Sacramento	08AW003585	Morgan, Timothy	03/13/08	El Dorado
Sacramento	08AW003585	Nelson, Donald	03/12/08	El Dorado
Silicon Valley	07GW000487	Nguyen, Gigi	03/25/08	Santa Clara
San Diego	07EW007187	Nissim, Kabalo	03/12/08	San Diego
San Diego	07EW007187	Nogueron-Vazquez, Anastacio	03/13/08	San Diego
San Diego	07EW007187	Ochoa, Gaston	03/12/08	San Diego
Benicia	08BW004289	Ochoa, Guadalupe	03/12/08	Napa
Benicia	08BW004289	Oreja, Anthony	03/13/08	Napa
Benicia	08BW004289	Orozco, Ramiro	03/12/08	Napa
San Diego	07EW007187	Owens, John	03/13/08	San Diego
Benicia	08BW004289	Perez, Jesus	03/13/08	Napa
Sacramento	08AW003585	Perez, Pedro	03/12/08	El Dorado
Silicon Valley	07GW000487	Pham, Jordan	03/25/08	Santa Clara
San Diego	07EW007187	Plouff, David	03/12/08	San Diego
Sacramento	08AW003585	Power, Michael	03/12/08	El Dorado
So. LA County	06CW012485	Preza, Louis	03/25/08	Los Angeles
San Diego	07EW007187	Quintana, Edwin	03/13/08	San Diego
San Diego	07EW007187	Ramos, Esteban	03/12/08	San Diego
Sacramento	08AW003585	Revell, Dan	03/12/08	El Dorado
So. LA County	07CW005918	Richie-Perez, Rosario	03/06/08	Los Angeles
Sacramento	08AW003585	Robertson, James	03/12/08	El Dorado
Benicia	07BW011312	Rockwell, Janeen	03/20/08	Contra Costa
San Diego	07EW007187	Rodriguez, Jesus	03/13/08	San Diego
San Diego	06EW009980	Romo, Ramon	03/20/08	San Diego
Benicia	08BW004289	Saldana-Gutierrez, Blas	03/13/08	Napa
San Diego	07EW007187	Sandoval, Gabino	03/13/08	San Diego
Benicia	08BW004289	Sayles, Dimple	03/12/08	Napa
San Diego	07EW007187	Silveira, Paul	03/13/08	San Diego
Sacramento	08AW003585	Smith, James	03/13/08	El Dorado
Silicon Valley	07GW000493	Tang, Nikki	03/25/08	Santa Clara
Sacramento	08AW003585	Timmerman, Donald	03/13/08	El Dorado
Silicon Valley	07GW000493	Tran, Xuan	03/25/08	Santa Clara
Silicon Valley	07GW000493	Truong, Khang "Kevin"	03/25/08	Santa Clara
So. LA County	07CW006293	Tucker, Kyle	03/05/08	Los Angeles
Sacramento	06AW004792	Turner, Nadine	03/07/08	San Joaquin
San Diego	07EW007187	Turrado, Francisco	03/13/08	San Diego
Sacramento	08AW003585	Vanarker, Kevin	03/13/08	El Dorado
San Diego	07EW007187	Velazquez, Angel	03/12/08	San Diego

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

March 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
San Diego	07EW007187	Velzaquez, Arturo	03/12/08	San Diego
Sacramento	08AW003585	Ventura, Salvador	03/13/08	El Dorado
Sacramento	08AW003585	Villa, Jesus	03/13/08	El Dorado
San Diego	07EW007187	Vuong, Andy	03/12/08	San Diego
Sacramento	06AW020038	Whiteley, Shane	03/14/08	Sacramento
Sacramento	08AW003585	Williams, Michael	03/12/08	El Dorado
Sacramento	08AW003585	Young, Louis	03/13/08	El Dorado

April 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Valencia	07JW006972	Aguilar, Victor	04/08/08	Los Angeles
Valencia	07JW016940	Aldridge, Arnulfo	04/08/08	Los Angeles
Benicia	07BW011311	Gonzalez, Jorge	04/23/08	Contra Costa
Valencia	05JW000772	Haggard, Harold	04/10/08	Los Angeles
Benicia	07BW008004	Hall, Charles	04/21/08	Sonoma
Inland Empire	07HW016931	Hull, Judith	04/08/08	San Bernardino
Inland Empire	07HW016933	Jitmanowan, Dawnruetai	04/10/08	San Bernardino
Benicia	07BW011297	Martinez, Hilario	04/23/08	Contra Costa
Orange	07DW019699	Mena, Herlindo	04/17/08	Orange
Silicon Valley	07GW000487	Nguyen, Trina	04/04/08	Santa Clara
Sacramento	08AW003585	Olson, Clinton	04/04/08	El Dorado
Benicia	06BW019697	Sargiotto, Stephanie	04/17/08	Alameda
Silicon Valley	06GW023427	Squires, Stephen	04/29/08	San Mateo
Silicon Valley	05GW006970	Tiet, Khanh	04/08/08	Santa Clara
Silicon Valley	05GW006970	Tiet, Muoi	04/02/08	Santa Clara
Silicon Valley	05GW006970	Tiet, Travis	04/02/08	Santa Clara
Silicon Valley	05GW006970	Tiet, Vincent	04/02/08	Santa Clara
Benicia	07BW020085	Uesi, Timote	04/15/08	Contra Costa
So. LA County	07CW011789	White, Laslo	04/09/08	Los Angeles
Benicia	07BW004923	Yousuf, Nashwan	04/21/08	Alameda
Sacramento	08AW003585	Zhidovlenko, Aleksey	04/04/08	El Dorado
Sacramento	08AW003585	Zhidovlenko, Pavel	04/04/08	El Dorado
Sacramento	08AW003585	Zhidovlenko, Sergey	04/04/08	El Dorado

May 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Silicon Valley	08GW009364	Albor, Jose	05/06/08	Monterey
Benicia	07BW011305	Algnarazi, Faliz	05/15/08	Contra Costa
Inland Empire	07HW016929	Castro, Hilda	05/22/08	San Bernardino
San Diego	07EW011545	Cruz, Carlos	05/21/08	San Diego
Silicon Valley	08GW009396	Galleguillos, Luciano	05/06/08	Monterey
Valencia	06JW003586	Garcia, Adan	05/22/08	Los Angeles

Appendix # 5: Workers' Compensation Fraud Arrests (Fiscal Year 2007- 08) (continued)

May 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Inland Empire	07HW016929	Garcia, Rafael	05/22/08	San Bernardino
Inland Empire	05HW013344	Gardner, Michael	05/08/08	San Bernardino
Silicon Valley	08GW009182	Gonzalez, Adam	05/06/08	Monterey
Silicon Valley	08GW009481	Jones, Gary	05/06/08	Monterey
Silicon Valley	08GW009290	Kirkley, Benjamin	05/07/08	Monterey
Silicon Valley	08GW009302	Lleras, Jose	05/07/08	Monterey
Benicia	07BW011306	Orozco, Josephine	05/29/08	Contra Costa
San Diego	05EW008108	Pete, Tiffany	05/04/08	San Diego
Silicon Valley	08GW009412	Powning, Scott	05/06/08	Monterey
Inland Empire	08HW003758	Razo, Manuel	05/22/08	San Bernardino
Sacramento	06AW016048	Stanley, Steve	06/05/08	Yolo
San Diego	06EW003325	Varela-Martinez, Jose	05/07/08	Imperial
Benicia	04BW015752	Vogel, Jay	05/29/08	Alameda

June 2008

DOI Regional Office	Case Number	Suspect's Name	Arrest Date	Prosecuting Authority
Fresno	07FW010739	Brown, Lupe	06/10/08	Fresno
Benicia	06BW008261	Erb, Pamela	06/06/08	Alameda
Orange	05DW005895	Figueroa, Martha	06/25/08	Orange
Benicia	07BW010183	Gonzales, Frank James	06/18/08	San Francisco
Inland Empire	05HW013557	Hamilton, Paul	06/12/08	Riverside
Inland Empire	05HW013557	Hamilton, Susanna	06/11/08	Riverside

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08)

Alameda County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
H45082	Andriani, Lynette	Claimant Fraud	1 day(s) jail 60 month(s) probation	$27,150	
158540B	Brooks, Neikath	Uninsured Employer	36 month(s) prison	$9,330	
227122	Dixoon, Jinny	Uninsured Employer	65 day(s) jail 36 month(s) probation	$11,000	$1,000
113566	Fisiiahi, Sione	Uninsured Employer	2 day(s) jail 36 month(s) probation	$2,500	$400
158540B	Fletcher, Troy	Claimant Fraud	24 month(s) prison		
534081	Gonzales, Jorge	Uninsured Employer	180 day(s) jail 36 month(s) probation	$13,665	$2,500
H43663	Gonzalez, Jose Luis	Claimant Fraud	11 day(s) jail 60 month(s) probation		
H44840	James, Claude	Claimant Fraud	90 day(s) jail 60 month(s) probation	$45,000	
403360	Lopez, Regina	Claimant Fraud	1 day(s) jail 36 month(s) probation	$1,600	
402966	Malinczak, Joseph	Claimant Fraud	1 day(s) jail 36 month(s) probation		
222704	Munoz, Gilberto	Claimant Fraud	2 day(s) jail 36 month(s) probation		$750
155521	Ona, Godwin	Claimant Fraud	5 day(s) jail 60 month(s) probation		$1,000
H44580	Quilantang, Rachael	Claimant Fraud	2 day(s) jail 60 month(s) probation	$10,000	$1,000
H43147	Raines, Michael	Claimant Fraud	5 day(s) jail 60 month(s) probation	$7,000	
400468	Ramos, Jose	Claimant Fraud	360 day(s) jail	$7,500	
H44373	Spediacci, Wanda	Claimant Fraud	1 day(s) jail 60 month(s) probation	$13,300	$1,000

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Alameda County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
154149	Thompson, Irvin	Claimant Fraud	1 day(s) jail 60 month(s) probation	$10,000	$1,000
H43474	Viray, Aristotle	Claimant Fraud	15 day(s) jail 60 month(s) probation	$26,511	$1,000
531995	Wendi, Howard	Claimant Fraud	64 day(s) jail 36 month(s) probation	$10,000	$1,000
H45023	Yousuf, Nashwant	Claimant Fraud	1 day(s) jail 60 month(s) probation	$15,000	$1,500

Amador County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
62-71723	Demoss, Dylan	Claimant Fraud	36 month(s) probation	$2,713	$780
62-71721	Gaton, Karen	Claimant Fraud	15 day(s) jail 36 month(s) probation	$422	$655
04CR5684	Griffin, John	Claimant Fraud	120 day(s) jail 60 month(s) probation	$57,741	
07CR12189	Hankins, Darryl	Uninsured Employer			$3,000
62-71722	Leddy, Nicole	Premium Fraud	45 day(s) jail 36 month(s) probation		$15,000
62-71772	Looper, Amy	Premium Fraud	45 day(s) jail 36 month(s) probation		$4,000
62-80736	Marquez, Francisco	Uninsured Employer	12 month(s) probation		$2,120
08CR1377	Mashburn, Dennis	Uninsured Employer			$630
08CR1380	Quint, Richard	Uninsured Employer	12 month(s) probation		$5,120
08CR13771	Whitlock, Dale	Uninsured Employer	12 month(s) probation		$1,120

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Butte County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
DA060832	Clayton, Lloyd Duane	Uninsured Employer	36 month(s) probation		$2,000
DA060839	Storey, Brian Mitchell	Uninsured Employer	36 month(s) probation		$2,000

Contra Costa County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
1-131097-8	Adams, Amy Arlene	Claimant Fraud	36 month(s) probation 250 hour(s) community service	$50,609	$220
1-137201-0	Arguayo, Raul	Uninsured Employer	24 month(s) probation		$1,489
1-133110-7	Ayala, Marcelino	Uninsured Employer	24 month(s) probation		$3,100
1-133962-1	Dang, Be / Dang's Landscaping	Uninsured Employer	24 month(s) probation		$2,120
1-130986-3	Fishiiahi, Suli	Uninsured Employer	36 month(s) probation	$30,000	$120
1-132320-3	Gallego, Rudy	Uninsured Employer	24 month(s) probation		$3,120
1-130413-8	Gould, Robbie	Uninsured Employer	24 month(s) probation		$2,120
1-230717-2	Guzman, Miguel	Uninsured Employer	24 month(s) probation		$650
1-133448-1	Kershaw, Alex / A-1 Pizza, Inc. Dba Garlex Pizza & Ribs	Uninsured Employer	24 month(s) probation		$1,620
1-135497-6	Khashabi, Avissa	Uninsured Employer			$2,120
1-132641-2	Latu, Vitolio / Latu Concrete	Uninsured Employer	24 month(s) probation		$3,120
3-220410-4	Mitchell, Editha	Claimant Fraud	14 day(s) jail 36 month(s) probation 100 hour(s) community service	$36,118	$120

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Contra Costa County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
1-135561-9	Palu, Viliami	Uninsured Employer	24 month(s) probation 60 hour(s) community service		$120
1-136282-1	Rockwell-owens, Janeen	Uninsured Employer	12 month(s) probation		$520
1-131100-0	Ryan, Keith	Claimant Fraud	24 month(s) probation 100 hour(s) community service		$120
5-070980-8	Samuel, Marva	Claimant Fraud	36 month(s) probation 250 hour(s) community service	$8,562	$220
1-132282-5	Sau, Samiuela	Uninsured Employer	30 day(s) jail 24 month(s) probation		$120
1-132640-4	Sio, Tatafu / Aloha Construction	Uninsured Employer	24 month(s) probation		$3,120
1-133111-5	Truong, Thomas The / J&t Landscape	Uninsured Employer	24 month(s) probation		$1,620
1-135190-7	Uesi, Timote / Quality Concrete And Landscaping	Uninsured Employer	24 month(s) probation Restitution hearing set for 05/16/08.		$120

El Dorado County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
P07CRF0181	Avalos, Ruben Enrique / Avalos Concrete	Uninsured Employer	36 month(s) probation	$1,780	
P08CRM0648	Baker, Charles Allen	Other	36 month(s) probation		$1,870
P08CRM0652	Balderston, Ronald Dale	Other	24 month(s) probation		
P07CRM0435	Brewer, Keith Robert / Brewer Fence	Uninsured Employer	36 month(s) probation		$2,000
P08CRM0651	Broyles, Kelly Paul	Other	24 month(s) probation		$500

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

El Dorado County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
P08CRM0880	Buckley, Denis Walker	Other	24 month(s) probation		
P07CRM1316	Butcher, Scott Thomas / Sierra Nevada Sealcoating	Uninsured Employer	24 month(s) probation		$1,870
P07CRF0343	Carlile, Matthew Steven	Claimant Fraud	5 day(s) jail 18 month(s) probation		$2,046
P08CRM0379	Chesser, Arthur Paul	Uninsured Employer	36 month(s) probation		$1,870
P07CRF0397	Cruz, Hector Gonzales / Experienced Painters & Plasterers	Uninsured Employer	36 month(s) probation 80 hour(s) community service		$440
P07CRM1317	Digiacinto, Marco Charle	Other	24 month(s) probation		$600
P08CRM0642	Forrester, Larry Dell	Other	36 month(s) probation		
P07CRM1729	Godinez, Jesus Manuel	Uninsured Employer	24 month(s) probation		$1,870
P07CRF0375	Gomez, Juan Manuel Lope / Juan Lopez Services	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$200
P07CRM1521	Guardado, Alberto / Rhyno West Services	Uninsured Employer	36 month(s) probation	$14,655	
P07CRF0233	Hemman, Rodney James / California Paint Pros Inc.	Uninsured Employer	24 month(s) probation		$1,870
P08CRM0491	Kerner, Mark	Other	36 month(s) probation		
P07CRM1822	Kerner, Mark / Transformation Landscape Company	Uninsured Employer	36 month(s) probation		$1,730
P07CRF0374	Lilley, Daniel Scott / Dan The Man Home Repair And Maintenance	Uninsured Employer	36 month(s) probation		$200
P08CRM0635	Loera, Jesus Hernandez	Other	36 month(s) probation		$2,620

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

El Dorado County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
P07CRM0813	Markus, Gygory / Father & Son General Contracting	Uninsured Employer	24 month(s) probation	$8,000	$500
P07CRF0311	Meadows, Troy D	Other	180 day(s) jail 36 month(s) probation 80 hour(s) community service		
P08CRM0653	Morgan, Timothy Justin	Other	36 month(s) probation		
P07CRM1518	Moultrie, David	Uninsured Employer	12 month(s) probation		$905
P07CRM0831	Perdichizzi, Frank Patrick / El Dorado Tree Experts	Uninsured Employer			$1,880
P08CRM0640	Perez, Pedro Vela	Uninsured Employer	36 month(s) probation		
P07CRM0641	Reed, Paul Thomas / Lawn & Yard Maintance	Uninsured Employer	18 month(s) probation		$905
P07CRM0430	Reid, Richard Cameron	Uninsured Employer	24 month(s) probation		
P07CRF0310	Rossier, Chase Oliver / Rossier Home Restoration	Uninsured Employer	24 month(s) probation 40 hour(s) community service	$200	
P07CRM0503	Rozzi, Mark John / Quality Fence Company	Uninsured Employer	36 month(s) probation		$400
P07CRM1326	Rue, Donald Walden / Fernley Groundskeeping Llc	Other	18 month(s) probation		$500
P07CRF0507	Salmon, Mark	Other		$15,000	
P07CRM1736	Santana, Rogelio R	Uninsured Employer	24 month(s) probation		$1,870
P07CRM1739	Scott, John Randolph / Absolute Mechanical	Uninsured Employer	24 month(s) probation		$1,870

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

El Dorado County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
P07CRF0311	Tanner, William Behle	Uninsured Employer	180 day(s) jail 36 month(s) probation 80 hour(s) community service		
P08CRM0647	Timmerman, Donald Wesley	Other			$1,000
P07CRM1187	Valdez, Ernest Mundo / Canyon Crest Construction	Uninsured Employer	36 month(s) probation	$14,655	
P08CRM0646	Vanarkel, Kevin Michael	Other	24 month(s) probation		$955
P08CRM0508	Ventura, Salvador Cervantes	Other	15 day(s) jail 36 month(s) prison		$480
P08CRM0508	Villa, Jesus Oseguera	Other	15 day(s) jail 36 month(s) prison		$480
P08CRM0644	Villa, Jesus Oseguera	Other			$480
P07CRM1297	Watkins, Mitchell Perry	Uninsured Employer	24 month(s) probation		$1,880
P08CRM0645	Young, Louis Charles	Other	36 month(s) probation		$1,870
P08CRM0745	Zhidovlenko, Sergey Pavlovich	Other	36 month(s) probation		$1,790

Kings County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
07FW010608	Ahmed, Saleh / Stop And Shop Market	Uninsured Employer	18 month(s) probation		$360
07FW010608	Alkobadi, Saleh / Family Market	Uninsured Employer	18 month(s) probation		$360
07FW010608	Aragon, Ruben / Aragon Paint & Body	Uninsured Employer			$360
07FW010608	Dhillon, Balwinder Singh / Mari-matt Mini Market	Uninsured Employer	36 month(s) probation		$360
07FW010608	Gameel, Numi / Stop And Go Market	Uninsured Employer	36 month(s) probation		$360

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
BA332761	Alcala, Armida / Sugar Foods Inc.	Claimant Fraud	2 day(s) jail 60 month(s) probation 200 hour(s) community service	$30,953	$220
MA040282	Angell, Aaron Barrett	Claimant Fraud	7 day(s) jail 36 month(s) probation		
7EA05475	Aquino, Jesus A. / Hi-d-hi Bar	Uninsured Employer	36 month(s) probation		$3,565
BA319447	Arceo, Ramon	Claimant Fraud	45 day(s) jail 60 month(s) probation	$7,367	$330
8GN00820	Baharian, Aida / King's Furniture Internatinal	Uninsured Employer	36 month(s) probation		$3,765
BA320757	Barrow, Gilbert	Claimant Fraud	1 day(s) jail 60 month(s) probation 500 hour(s) community service	$45,000	$693
BA330568	Basurto-aguire, Daniel J.	Claimant Fraud	2 day(s) jail 60 month(s) probation 84 hour(s) community service	$5,000	$220
BA288429	Bird, Robert Christman	Insider Fraud	365 day(s) jail 36 month(s) probation		
BA335048	Blake, Oswald J.	Claimant Fraud	365 day(s) jail 60 month(s) probation	$122,282	
8GN00709	Boyajian, Ara	Uninsured Employer	36 month(s) probation		$3,765
BA320699	Broquard, Charles / Charles	Premium Fraud	36 day(s) jail 36 month(s) probation 500 hour(s) community service	$10,000	$762

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
BA319393	Buckner, Jacqueline	Claimant Fraud	2 day(s) jail 24 month(s) probation 100 hour(s) community service	$12,000	$347
BA321304	Burke, Sheila	Claimant Fraud	44 day(s) jail 60 month(s) probation 300 hour(s) community service	$75,000	$693
BA296268	Campbell, Stephen	Claimant Fraud	60 month(s) probation 250 hour(s) community service	$23,000	$1,090
BA319546	Cano, Santa	Claimant Fraud	60 month(s) probation	$45,470	$220
BA330521	Catalano, Eloise	Claimant Fraud	60 month(s) probation 693 hour(s) community service	$19,038	$693
8JB03165	Chang, In Kyu / Yang Riung Shin	Uninsured Employer	36 month(s) probation		$3,720
BA285104	Chavez, James	Premium Fraud	1 day(s) jail	$392,000	$100
8AH00968	Chow, King Tin / Air In Flowers	Uninsured Employer	36 month(s) probation		$2,865
7JB10706	Coffine, Eric J. / Power Sign Fabrication	Uninsured Employer	24 month(s) probation		$1,020
BA288429	Contreras, Jun Nigh C.	Insider Fraud	44 day(s) jail 48 month(s) probation	$250,000	$660
BA288429	Contreras, Richard R.	Insider Fraud	180 day(s) jail 60 month(s) probation	$250,000	$660
7EA10747	Delgado, Rosa Lombero / Arna Cantina & Resturant	Uninsured Employer			$1,130

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
BA337003	Dixon, Richard A.	Claimant Fraud	60 month(s) probation 150 hour(s) community service	$8,509	$693
7JB10702	Duarte, Gloria / New Beriatric Weight Clinic	Uninsured Employer	24 month(s) probation		$1,020
BA321016	Figueroa, Alfredo E.	Claimant Fraud	36 month(s) probation 100 hour(s) community service	$990	$693
BA334405	Flores, Lizeth	Claimant Fraud	180 day(s) jail 60 month(s) probation	$18,752	$693
BA317568	Foster, Vern	Claimant Fraud	2 day(s) jail 24 month(s) probation 100 hour(s) community service	$2,349	$347
BA319195	Garcia, Adan	Claimant Fraud	24 day(s) jail 60 month(s) probation 150 hour(s) community service	$9,900	$220
7JB05418	Hasbun, Michelle / Joann Barrel House	Uninsured Employer	12 month(s) probation		$1,920
BA312189	Hayes, Sandra	Claimant Fraud	300 day(s) jail 60 month(s) probation	$2,000	$693
7WW02007	Henry's Auto Repair	Uninsured Employer	24 month(s) probation		$3,755
BA325039	Hubbert, Sekira Ebvoniece	Claimant Fraud	24 month(s) prison	$18,197	$693
7JB10703	Huynh, Nam / A Plus Furniture	Uninsured Employer	24 month(s) probation		$1,900
BA320746	Hwang, Inbaek	Premium Fraud	24 month(s) probation	$40,000	$120
BA310759	Inc, Cover All	Premium Fraud	60 month(s) probation	$6,300,000	$200
8GN00706	Kim, Danny	Uninsured Employer	36 month(s) probation		$3,765

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
8AH00966	Li, Ka Wing / Promax Motorsports	Uninsured Employer	24 month(s) probation		$3,400
7BJ10704	Lien, Dong / Nice Cleaners	Uninsured Employer	6 month(s) probation		$1,920
BA333833	Luzcamonas, Jorge	Claimant Fraud	3 day(s) jail 60 month(s) probation 150 hour(s) community service	$21,869	$693
BA232031	Mancini, Michael	Claimant Fraud	3 day(s) jail 36 month(s) probation 250 hour(s) community service	$15,650	
BA320623	Martinez, Maricela C.	Claimant Fraud	1 day(s) jail 24 month(s) probation 50 hour(s) community service	$2,000	$693
7JB10707	Mckenney, Lynn D. / Cruise Holidays	Uninsured Employer	24 month(s) probation		$3,720
BA319989	Mendoza, Magdaleno / Mariscos Pureto Escondido	Claimant Fraud	43 day(s) jail 60 month(s) probation	$193,926	$693
BA334503	Miller, Steven K.	Claimant Fraud	28 day(s) jail 60 month(s) probation	$10,000	$693
7EA05474	Montoya, Petrona / Ericka's Place	Uninsured Employer	24 month(s) probation		$900
BA317926	Mordoki, Alberto	Premium Fraud	24 month(s) prison		$200
BA337089	Moroz, Gene / Asynergy Corp.	Premium Fraud	60 month(s) probation 400 hour(s) community service	$186,000	$693
8GN00705	Mostafaui, Fred / Tool Shack	Uninsured Employer	36 month(s) probation		$3,765

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
BA325570	Negrete, Robert	Claimant Fraud	7 day(s) jail 60 month(s) probation 100 hour(s) community service	$22,919	$693
BA326166	Nguyen, Thanh Tan	Claimant Fraud	2 day(s) jail 36 month(s) probation 50 hour(s) community service	$12,000	$693
BA329983	Oandasan, Dexx / Ralphs Grocery	Claimant Fraud	36 month(s) probation	$6,023	$2,445
BA320907	Plascencia, Uriel / Up Landscape	Other	30 day(s) jail 60 month(s) probation	$85,244	$693
BA293831	Portillo, Sabela M.	Claimant Fraud	3 day(s) jail 24 month(s) probation 100 hour(s) community service	$12,000	$347
BA317097	Reyes, Guadalupe	Claimant Fraud	3 day(s) jail 12 month(s) probation	$20,000	$693
BA333279	Rivas, James	Claimant Fraud	27 day(s) jail 36 month(s) probation	$12,800	$220
BA315955	Rosales, Gloria	Claimant Fraud	24 month(s) probation 50 hour(s) community service		$500
7BF01334	Rubio, Armando / Alpha Cleaners	Uninsured Employer	2 month(s) probation		$3,565
BA319972	Sandoval, Sonia	Claimant Fraud	5 month(s) probation 200 hour(s) community service	$15,000	$693
BA320887	Scott-charles, Beverly A.	Claimant Fraud	1 day(s) jail 60 hour(s) community service	$4,927	$693

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
8GN00710	Shirvanyan, Ara K.	Uninsured Employer	36 month(s) probation		$5,565
BA319903	Smith Jr., Harry	Claimant Fraud	20 day(s) jail 36 month(s) probation	$10,000	$693
BA320847	Tejas-soriano, Mario M.	Claimant Fraud	3 day(s) jail 36 month(s) probation 100 hour(s) community service	$3,270	$693
8AH00967	Therapy, Wellness Physical / Wellness Physical Therapy	Uninsured Employer	24 month(s) probation		$3,755
8GN00704	Tokmadjian, Hosvep	Uninsured Employer	36 month(s) probation		$3,665
8GN00708	Tomassian, Krikor A.	Uninsured Employer	12 month(s) probation		$3,765
BA319567	Travis, Latanya Aretrea	Claimant Fraud	1 day(s) jail 24 month(s) probation	$2,728	$347
8AH00969	Truong, Tom / Dr. Tom Troung Pain Clinic	Uninsured Employer	36 month(s) probation		$2,865
BA323598	Tullio, Dena A. / Behavioral Health	Claimant Fraud	24 month(s) probation	$22,000	$100
BA318987	Valdez, Ricardo	Claimant Fraud	6 day(s) jail 60 month(s) probation 120 hour(s) community service	$9,051	$1,040
BA318351	Vila, Rafael	Claimant Fraud	36 month(s) probation 100 hour(s) community service	$2,000	$347
7JB10705	Vt Fabricating	Uninsured Employer	24 month(s) probation		$1,021

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Los Angeles County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
BA308648	Walker, Stephen	Claimant Fraud	18 day(s) jail 60 month(s) probation 150 hour(s) community service	$57,910	$693
8JB03169	Wang, Chiang / Chiang Wang Chiropractic Clinic	Uninsured Employer	36 month(s) probation		$3,720

Marin County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
SC146796	Hairston, Cheryl Yvette / Rafael Convalescent Hospital	Claimant Fraud	30 day(s) jail 36 month(s) probation 40 hour(s) community service	$12,642	$200
SC128128	Murray, Forrest Billy / Nordstrom's	Claimant Fraud	36 month(s) probation 50 hour(s) community service	$13,000	$100
SC152485	Spiliotis, Mary / Marin County Office Of Education	Claimant Fraud	36 month(s) probation 50 hour(s) community service Supervised probation	$19,367	$600

Merced County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
29834A	Aguilar, John / Foster Farms/aaa	Multiple Entities Provider Fraud	36 month(s) probation 100 hour(s) community service 6 mos. prob. Suspended		$572
02-241	Amado, Julius / Liberty Mutual	Claimant Fraud	180 day(s) jail 36 month(s) probation	$56,520	

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Merced County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
MM206323	Chavez, Alberto L. / Liberty Mutual	Claimant Fraud	36 month(s) probation 120 hour(s) community service	$5,000	
MM208404	Chavez, Jesus G.	Premium Fraud	24 month(s) probation		$320
29834B	Delavara, Juan / Foster Farms/aaa	Multiple Entities Provider Fraud	36 month(s) probation 60 hour(s) community service 4 mos. County Jail Suspended		$540
MF44834	Jimenez, Adrian / Scif	Premium Fraud	180 day(s) jail 36 month(s) probation	$240,698	$1,072
MF41863	Lopez-calderon, Jose / Zenith Insurance	Claimant Fraud	36 month(s) probation	$6,500	$420
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
03-235	Singh, Bachitter / Foster Farms	Claimant Fraud	36 month(s) probation		
MF40681	Soto, Antionio / Liberty Mutual	Claimant Fraud	36 month(s) probation		
29834F	Thao, Ngia / Foster Farms/aaa	Multiple Entities Provider Fraud	36 month(s) probation 120 hour(s) community service		$200

Monterey County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
WCF07-0061	Duarte, Jose Luis / Self-employed	Claimant Fraud	36 month(s) probation		$750
WCF07-0057	Law, John Dale / Self-employed	Other	36 month(s) probation		$780

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Monterey County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
WC07-0002	Leon, Rigoberto / Dole Fresh Vegetables	Claimant Fraud	20 day(s) jail 36 month(s) probation		
WCF07-0055	Matias, Gilberto Zaveche / Self-employed	Other	36 month(s) probation		$780
WCF07-0012	Navarro, Mario / Growers Express	Claimant Fraud		$23,637	$100
WCF07-0042	Sanabria, Jorge Espinoza / Self-employed	Uninsured Employer	36 month(s) probation		$500
WCF07-0062	Sanchez, Gerardo Artemio / Self-employed	Other	24 month(s) probation		$180
WCF07-0056	Serratos, Andrade Fernando / Self-employed	Other	12 month(s) probation		$750
WCF07-0063	Taylor, Richard John / Self-employed	Claimant Fraud	36 month(s) probation		$430
WCF07-0065	Trejo, Juan Reyes / Self-employed	Claimant Fraud	36 month(s) probation		$1,000
WCF07-0070	Vasquez, Jose Luis / Jlv Plans Designer	Claimant Fraud	365 day(s) jail 36 month(s) probation	$160,861	$600

Orange County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
07CF2076	Aguilera, Maria Lourdes / Zenith Insurance Company	Claimant Fraud	36 month(s) probation		
08CF1235	Chaverri, Vannessa	Premium Fraud	90 day(s) jail 36 month(s) probation	$486,172	$200
05CF1540	Corea, Raul Rueda / Republic Indemnity	Claimant Fraud		$87,164	
08CM01382	Daghlian, Peter / Psc Auto Electric	Uninsured Employer			$100
07CM10292	Ensor, Douglas Alan / Alan's Wheelchairs And Medical Products	Uninsured Employer	36 month(s) probation		$10,000

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Orange County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
07CF3696	Fuentes, Odir Castillo / Berkshire Hathaway Homestate	Claimant Fraud	48 month(s) prison	$92,992	$10,000
08CM00597	Garcia, Elvira / European Cleaners	Uninsured Employer			$100
07CM10727	Grillo, Dominico / La Familia Inc	Uninsured Employer			$10,000
08CM02147	Hakeem, Mazin Sultan -al / Advanced Health Care Group	Uninsured Employer			$500
07CF1164	Hernandez, Alfonso Ortiz / Sirod Foam And Packaging	Claimant Fraud	90 day(s) jail	$5,539	
08CM02731	Ko, Suzanne / Beach Cleaners	Uninsured Employer			$100
07CM10293	Morales, Paularino / Gorilla's Metal Polishing	Uninsured Employer	36 month(s) probation		$10,000
07CF0957	Munsey, Susan Merry / Baldwin Park Unified School District	Claimant Fraud	36 month(s) probation	$18,252	$100
07CF1163	O'patterson, Garry Edward / Budget Rent A Car	Claimant Fraud	60 month(s) probation	$103,769	$400
08CM01383	Perez, Johnny / Car Stereo	Uninsured Employer			$200
05CM00959	Reynoso, Manuel / Orange County Metal Processing	Uninsured Employer	36 month(s) probation	$2,000	$14,500
07CM12132	Rivera, Enrique / A&e Auto Service	Uninsured Employer	12 month(s) probation		$10,100
06CF1121	Romero, Peter Villagrana / Gallagher Basset	Claimant Fraud	223 day(s) jail 36 month(s) probation	$25,000	$200
06CM11267	Russel, Samuel George / Oasis Landscaping	Uninsured Employer	3 years informal probation		$2,000
07CM10884	Segura, Manuel Navarette / Segura's Metal Polishing	Uninsured Employer	36 month(s) probation		$10,000

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Orange County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
08CM02145	Seo, Mina / Caruso Cleaners	Uninsured Employer			$100
08CF1171	Solorio, Herlindo Mena	Claimant Fraud	18 day(s) jail 36 month(s) probation	$1,121	$400
06CF3417	Tagliarini, Joseph Michael / Intergrative Wellness Group Clinic	Multiple Entities Provider Fraud		$547	
07CM10295	Wolf, Andrew William / Schneider Bmw Service	Uninsured Employer	18 day(s) jail 36 month(s) probation		$10,000

Riverside County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
RIM 508816	Acevedo, Guadalupe Judith	Claimant Fraud	36 month(s) probation		$1,000
SWM066138	Almazan , Fidencio E.	Uninsured Employer	36 month(s) probation		$1,000
RIM508814	Alvarez, Gustavo	Uninsured Employer	36 month(s) probation		$1,000
RIM508815	Assink, Alvin Clair	Uninsured Employer			$554
SWM066318	Ayoung, Kim	Uninsured Employer	36 month(s) probation		$367
RIM 513959	Banos, Oscar David Urbina	Claimant Fraud	36 month(s) probation		$1,000
RIF135381	Bartelli, Mariano Michael	Premium Fraud	120 month(s) prison 36 month(s) probation	$5,000	
RIM 500475	Cao, Viet Thanh	Uninsured Employer	36 month(s) probation		$625
RIF 131049	Carreon, Manuel	Claimant Fraud	24 month(s) prison		
INF 059524	Cielo, Jose Reyes	Claimant Fraud	4 day(s) jail 36 month(s) probation	$4,548	
RIM 500473	Diaz, Celso	Uninsured Employer	36 month(s) probation		$625
INM 182074	Dickherber, Michael James	Claimant Fraud	36 month(s) probation		$367

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Riverside County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
RIM 500542	Garcia , Teresa	Uninsured Employer	5 day(s) jail 36 month(s) probation		$1,000
RIM 513982	Garcia, Brijido H	Uninsured Employer	36 month(s) probation		$1,000
RIM 512022	Ghadiri, Hamid	Uninsured Employer	36 month(s) probation		$1,000
RIM 513777	Gonzalez, Hector M. Cardenas	Uninsured Employer	36 month(s) probation		$1,000
INM 187475	Hanna, Essam Raghes	Uninsured Employer	36 month(s) probation		$1,000
RIM 475228	Ibarra-rodriguez, Francisco Javier	Uninsured Employer	36 month(s) probation		$1,000
INF 061136	Johnson, Chad	Uninsured Employer	30 day(s) jail 18 month(s) probation	$500	
RIM 513970	Leon, Juan Madrigal	Uninsured Employer	36 month(s) probation		$1,000
RIF 139879	Marquez, Jose Santiago	Claimant Fraud	60 day(s) jail 36 month(s) probation		
SWM 067110	Mcclellan, Mark Alan	Uninsured Employer	36 month(s) probation		$1,000
RIF 105454	Monugian, Jimmy	Claimant Fraud	170 day(s) jail 36 month(s) probation		$19,800
RIM 508811	Morris, Wendell Earl	Uninsured Employer	36 month(s) probation		$1,000
INM 187475	Rizk, Youssef Habibe	Uninsured Employer	36 month(s) probation		
RIM 500474	Rodriguez, Mike / Nacho's Restaurant	Uninsured Employer	36 month(s) probation		$90
RIM 500476	Soto, Jaime	Uninsured Employer	5 day(s) jail 36 month(s) probation		$1,000
RIM 510327	Swartz, Julie Alicia	Uninsured Employer	36 month(s) probation		$10,000

Sacramento County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
07M09653	Afagh, Bahram / Not Just Japanese Only	Uninsured Employer	36 month(s) probation		$252

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Sacramento County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
06F01939	Amezquita, Jose / Aka:salvador Cortez	Claimant Fraud	90 day(s) jail 48 month(s) probation	$16,698	$600
07F01021	Beem, Marcia Lee	Claimant Fraud	9 day(s) jail 36 month(s) probation	$3,500	$100
07M13982	Bhamani, Akbar Aly	Uninsured Employer	36 month(s) probation	$2,205	$100
06F08246	Clements, Kevin A	Claimant Fraud	180 day(s) jail 48 month(s) probation	$37,500	$200
07M02501	Forristall, David Anthony / Innerspace Garage Cabinets	Uninsured Employer	36 month(s) probation 540 hour(s) community service		$2,600
04F01567	Hawarneh, Kecia	Claimant Fraud	2 VOP		
06F03502	Hinton, John Paul	Claimant Fraud	90 day(s) jail 48 month(s) probation	$12,082	$200
07M09654	Ho, Hai Ngoc / Beta Smog & Tune	Uninsured Employer	36 month(s) probation		$0
06F06779	Holloway, Lashundra Glyn	Claimant Fraud	90 day(s) jail 36 month(s) probation		$100
07M09659	Khan, Rafi Raza / Purrfect Auto Services	Uninsured Employer	36 month(s) probation		$252
06M09360	Lal, Akash Andrew / El Camino Tile & Flooring	Other	36 month(s) probation		$1,200
06F08219	Lucena, June	Claimant Fraud	Consolidated w/ 04F10845		
04F10845	Lucena, June Ann	Claimant Fraud	Guilty Jury Trial		
07M09651	Marmolejo, Eleazar / Amigo Auto Repair	Uninsured Employer	36 month(s) probation		$252
07M09658	Medina, Benjamin Ramos / Ramos Auto Repair	Uninsured Employer	36 month(s) probation		$252

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Sacramento County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
04F06782	Pena, Martin Zavala	Claimant Fraud	36 month(s) probation 132 hour(s) community service		$100
07F06100	Phillippi-veloz, Shannon	Claimant Fraud	180 day(s) jail 60 month(s) probation	$36,077	$200
07F06918	Pillay, Lao Kumaran	Claimant Fraud	30 day(s) jail 36 month(s) probation	$8,702	$100
07M09657	Sarguis, Victor / Smog Usa	Uninsured Employer	36 month(s) probation		$252
07M09652	Singh, Mohan Dhillon / King Auto Body	Uninsured Employer	36 month(s) prison		$556
07F06317	Smith, Allen James	Claimant Fraud	150 day(s) jail 60 month(s) probation	$24,034	$200
07M13330	Soderquist, James Noel / Valley West Const.	Uninsured Employer	36 month(s) probation		$100
07M09656	Turknett, Kenneth Dewayne / Ken & John's Auto Repair	Uninsured Employer	36 month(s) probation		$100
07M04731	Vilchitsa, Aleksandr Vladimirovich / Gutters Plus	Uninsured Employer	36 month(s) probation		$252

San Bernardino County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
MVI704170	Albatche, Joseph / Dba Joe's Market	Uninsured Employer	24 month(s) probation		$2,130
FWV034928	Amezcua, Lazaro	Claimant Fraud	36 month(s) probation 250 hour(s) community service	$51,590	$200
FWV701273	Cardenas, Raul	Claimant Fraud	36 month(s) probation		$508

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Bernardino County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
FSB060090	Castillo, Jose	Claimant Fraud	24 month(s) probation 80 hour(s) community service	$20,808	$110
MSB705712	Chung, Soo Ok / Dba Gold Snack Bar	Uninsured Employer	24 month(s) probation		$5,130
FVI702180	Davies, Michelle	Claimant Fraud	36 month(s) probation 100 hour(s) community service	$25,000	$130
FSB054302	Day, Matthew	Other	36 month(s) probation	$74,477	$200
MSB803487	De Alvarez, Santa / Dba El Tepeyac Mexican Restaurant	Uninsured Employer	36 month(s) probation		$10,130
FSB052669	Denton, Yolanda	Claimant Fraud	60 month(s) probation	$8,431	$220
FSB046925	Diaz, Luis / Pdl	Premium Fraud	36 month(s) probation	$90,000	$110
FWV039955	Digiorgio, Laura	Claimant Fraud	Not Sentenced Yet.		
FSB039292	Doss, Deborah	Claimant Fraud	60 month(s) probation		
FSB056205	Echevarria, Raul Lara	Claimant Fraud	90 day(s) jail 60 month(s) probation	$35,000	$200
MCH701496	Feuer, Todd / Dba Jcs Maintenance Inc.	Uninsured Employer	24 month(s) probation		$10,110
FSB044713	Franco, Esteban	Claimant Fraud	24 month(s) probation 100 hour(s) community service	$25,000	$130
MSB802928	Gaona, Manuel / Dba Super Duper Video	Uninsured Employer	24 month(s) probation		$2,610
FSB059857	Gebrimikael, Neguse	Claimant Fraud	100 hour(s) community service	$82,076	$200

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Bernardino County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
FSB705172	Gibson, Jeanae	Claimant Fraud	24 month(s) probation 80 hour(s) community service	$15,000	$110
FWV700201	Hall, Judy	Claimant Fraud	24 month(s) probation 100 hour(s) community service	$12,000	$130
MSB705711	Han, Man Woong / Dba Dream Fashion	Uninsured Employer	24 month(s) probation		$5,000
MVI801036	Hull, Judith / Dba Carousel Faire	Uninsured Employer	24 month(s) probation		$10,000
MSB802562	Hwang, Sam / Dba Sam's Jewelry	Uninsured Employer	24 month(s) probation		$2,110
MVI801115	Jitmanowan, Dawnuetai / Dba Go Bangkok	Uninsured Employer	36 month(s) probation		$5,000
MSB706986	Jung, Eunjoo / Dba A1 Cleaners	Uninsured Employer	24 month(s) probation		$5,130
MVA052974	Kim, Dae Jung / Dba Just 5	Uninsured Employer	36 month(s) probation		$2,130
FSB702910	Lopez, Irene	Claimant Fraud	36 month(s) probation 100 hour(s) community service	$25,917	$110
MSB097598	Macgregor, Robert / Dba Fna Cycle & Performance	Uninsured Employer	24 month(s) probation		$5,130
MSB701100	Makamerah, Maher / Dba Mario's Italian Pizza	Uninsured Employer	36 month(s) probation		$6,130
FVI700066	Melvin, Larry	Claimant Fraud	180 day(s) jail 60 month(s) probation	$60,000	$200
FSB038723	Mitchell, Rosemary / Dba Steel Masters	Premium Fraud	365 day(s) jail 60 month(s) probation	$1,475,462	$200
MSB802124	Olson, Eric / Dba Eric's House Painting	Uninsured Employer			$508

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Bernardino County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
MWV801209	Pacheco, Leonardo / Dba Leo's Party Rental	Uninsured Employer	36 month(s) probation		$3,630
MSB800647	Palacios, Octavio / Dba Mariscos La Perla Del Mar	Uninsured Employer	24 month(s) probation 80 hour(s) community service		$2,200
FVI700773	Pascone, Mark	Claimant Fraud	1 day(s) jail 36 month(s) probation	$40,758	$200
MSB700880	Ramirez, Beatriz / Dba Sky Water & Ice	Uninsured Employer	24 month(s) probation		$415
FSB058542	Richardson, Iris	Claimant Fraud	36 month(s) probation	$15,000	$220
MCH800681	Roca, Hilda / Dba Mariscos El Rafa	Uninsured Employer	36 month(s) probation		$5,110
FSB19667	Rose, Kevin	Claimant Fraud	12 month(s) probation	$29,896	$1,200
FWV702521	Saltsman, William	Claimant Fraud	36 month(s) probation	$9,976	$200
FSB039847	Shakouj, Suheil	Claimant Fraud	60 month(s) probation	$15,085	$600
MSB802563	Silva, Jose / Dba Jose's Ice Cream	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$2,110
FWV037882	Swarthout, Cherie	Claimant Fraud		$12,383	$130
MSB800538	Tegge, Scott / Dba Mts Construction	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$2,000
FSB057973	Tobin, Perry	Claimant Fraud	36 month(s) probation	$40,000	$220
MSB706957	Touma, Faisal / Dba M&c Liquor	Uninsured Employer	24 month(s) probation		$5,130
FSB059925	Vallin, Jr., Robert	Claimant Fraud	120 day(s) jail 36 month(s) probation	$14,026	$200
MCH701891	Yu, Arn / Dba Guiseppe's Pizza	Uninsured Employer	24 month(s) probation		$4,130

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M015499	A Professional Corp. / J. Steven Mchale	Uninsured Employer	36 month(s) probation	$7,500	$120
M028145	Americasia Internat. Inc.	Uninsured Employer	36 month(s) probation	$1,000	$120
M027844	Ayoub, Sal	Uninsured Employer	1 day(s) jail 36 month(s) probation		$156
ABZ417	Baez, Angelina	Claimant Fraud	24 month(s) prison	$10,449	$400
M034501	Bahriz, Abdel	Uninsured Employer	1 day(s) jail 36 month(s) probation	$5,000	$120
M010609	Bertsch, Ryan	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
M026851	Bunting, Ilana	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M040576	Buvel, Janice	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
ABZ285	Cabanas, George	Claimant Fraud	Sent. pending	$9,367	
ABZ479	Camenzind, Daniel	Claimant Fraud	180 day(s) jail 60 month(s) probation 120 hour(s) community service 45 days Work Furlough	$38,667	
M044542	Castaneda, Jose	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
M031108	Castano, George	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$95
M039955	Correia, Paul	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
ABZ712	Ellis, Frederick	Uninsured Employer	40 month(s) prison	$179,000	$700
ACC527	Ellis, Frederick	Uninsured Employer	24 month(s) prison 24 months concurrent	$400	$400

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M026808	Estrada, Juan	Uninsured Employer	36 month(s) probation	$500	$120
M041901	Figueroa, Osiel	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$145
ABZ908	Fogg, Frank	Premium Fraud	1 day(s) jail 320 hour(s) community service	$2,251	$1,119
ABZ721	Gamboa, Henry	Premium Fraud	1 day(s) jail 36 month(s) probation	$400	$400
ABZ721	Gamboa, Manuel	Premium Fraud	1 day(s) jail 36 month(s) probation 200 hour(s) community service		$500
ABZ721	Gamboa, Sostenes	Premium Fraud	1 day(s) jail 36 month(s) probation	$1,400,000	$500
M045098	Garcia, Brandy	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,250	$120
M044539	Garcia, Esperanza	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$120
M045098	Garcia, Filiberto	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,250	$120
M044539	Garcia, Rogelio	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
M023580	Ghai, Kulbir	Uninsured Employer	1 day(s) jail 36 month(s) probation	$4,000	$120
M03450	Godinez, Carlos	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
ACD772	Gomez, Eric	Uninsured Employer	2 day(s) jail 36 month(s) probation 80 hour(s) community service	$1,070	$250

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M002917	Gonzalez, Miguel	Uninsured Employer	1 day(s) jail 36 month(s) probation	$4,000	$120
M014182	Guerrero, Pedro	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$114
M027845	Hernandez, Juan	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
M047880	Herrera, Javier	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,250	$120
M015497	Huang, Ming-chen	Uninsured Employer	1 day(s) jail 36 month(s) probation		$156
ACD559	Hudanich, Michael	Uninsured Employer	Sent. pending	$200	
ABZ377	Hunt, Gary	Claimant Fraud	1 day(s) jail 36 month(s) probation	$6,200	$200
M013651	Ibrahim, Mark	Uninsured Employer	1 day(s) jail 36 month(s) probation	$5,500	$120
M027844	International, Hotel Marketing	Uninsured Employer	36 month(s) probation	$7,200	$120
M004466	J. Rock Enterprise	Uninsured Employer	36 month(s) probation	$3,000	$120
ABK055	Jacobo, Arturo	Claimant Fraud	7 day(s) jail 36 month(s) probation	$5,673	$854
M014235	Jourdain, Bernard	Uninsured Employer	1 day(s) jail 36 month(s) probation	$25,000	$120
M026929	Kik Technology Inc.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$17,202	$10,120
M010609	Kimura, Hiromi	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	
ACD988	King, Kenneth	Claimant Fraud	Sent. pending	$8,179	
M026929	Knooihuizen, Bill	Uninsured Employer	1 day(s) jail Reduced to Infraction		$120

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M038053	Lee, Chung	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
ABZ721	Leon, Ernesto	Premium Fraud	1 day(s) jail 36 month(s) probation		$500
ABO627	Lopez, Dorotea	Claimant Fraud	36 month(s) probation 60 hour(s) community service	$17,359	$200
ACC932	Lowe, Andrew	Claimant Fraud	1 day(s) jail 36 month(s) probation	$4,510	$174
M038057	Lua, Maria	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
ACC768	Malek, Ladislav	Claimant Fraud	Sent. pending	$135,000	
ABZ976	Maness, John	Claimant Fraud	Sent. pending	$53,391	$680
ABW501	Mannero, Anthony	Uninsured Employer	1 day(s) jail 60 month(s) probation	$316,052	
ABZ908	Mayorga, Genard	Premium Fraud	1 day(s) jail 36 month(s) probation 15 hour(s) community service		$680
ABZ721	Mccarthy, Teresa	Premium Fraud	1 day(s) jail 36 month(s) probation		$500
M015499	Mchale, John	Uninsured Employer	1 day(s) jail 36 month(s) probation	$7,500	$156
ACD102	Mckeon, Darrell	Claimant Fraud	180 day(s) jail 36 month(s) probation	$1,531	$680
ACE170	Meda, Adalberto	Uninsured Employer	1 day(s) jail 36 month(s) probation 100 hour(s) community service	$500	$200

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M042754	Minassian, Garo	Uninsured Employer	1 day(s) jail 36 month(s) probation	$6,000	$120
ACC619	Miranda, Karen	Premium Fraud	1 day(s) jail 60 month(s) probation	$1,075,000	
M038058	Modeer, Solmaz	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
ACE172	Morast, Bryan	Uninsured Employer	1 day(s) jail 36 month(s) probation 100 hour(s) community service		$520
ACC926	Moreno, Raul	Claimant Fraud	Sent. pending	$7,000	
M044548	Najera, Albert	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$620
M038061	Ngo, Dung	Claimant Fraud	1 day(s) jail 36 month(s) probation	$1,500	$120
ABV669	Nicol, Christopher	Premium Fraud	1 day(s) jail 60 month(s) probation	$291,440	
M041902	Nunez, Elias	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
M013657	Ortiz, Jose	Uninsured Employer	1 day(s) jail 36 month(s) probation	$3,000	$120
ACD563	Palacios, Carlos	Uninsured Employer	2 day(s) jail		$220
ACC947	Pascua, Silverio	Premium Fraud		$55,000	$750
ABZ719	Ramirez, Silvestre	Claimant Fraud	1 day(s) jail 36 month(s) probation		$1,079
ABZ967	Rangel, Marco	Premium Fraud	1 day(s) jail 36 month(s) probation	$220,780	
ACC724	Reynolds, Jim	Claimant Fraud		$360	

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M041897	Rocco, Julio	Uninsured Employer	1 day(s) jail 36 month(s) probation	$250	$120
M038052	Rocha, Alfonso	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
ACD548	Romo, Ramon	Claimant Fraud	Sent. pending	$25,830	
ABY129	Saldivar, Blanca	Claimant Fraud	Sent. pending	$5,448	
ABZ478	Sanchez, America	Claimant Fraud	1 day(s) jail 60 month(s) probation 200 hour(s) community service	$57,000	$680
M038059	Sanchez, Jose	Claimant Fraud	1 day(s) jail 36 month(s) probation	$1,500	$120
M038059	Sanchez, Patricia	Uninsured Employer			$172
M044540	Sandy's Inc.	Uninsured Employer	1 day(s) jail 36 month(s) probation	$15,000	
ACD560	Santiago, Saul	Uninsured Employer	21 day(s) jail 24 month(s) probation	$120	
ACD593	Scarlette, Barry	Uninsured Employer	362 day(s) jail 36 month(s) probation	$200	$680
ABZ910	Schaible, Shaila	Premium Fraud	1 day(s) jail 90 month(s) probation	$100	$120
ACD566	Schmall, Chris	Uninsured Employer	2 day(s) jail 36 month(s) probation 40 hour(s) community service		$311
M044543	Serrano, Roselia	Uninsured Employer	1 day(s) jail 36 month(s) probation	$3,500	$145
ACC558	Soto, Felipe	Claimant Fraud	Sent. pending	$4,000	

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
M014191	Srg Paradise Villas Inc.	Uninsured Employer		$4,000	$120
ABZ812	Stanley, Richie	Uninsured Employer	180 day(s) jail 36 month(s) probation	$4,400	$680
M045096	Stidum, Lee	Uninsured Employer	1 day(s) jail 36 month(s) probation	$250	$120
M015497	Sun Moon, Perfumes, Inc.	Uninsured Employer	36 month(s) probation	$5,000	$120
M038055	Tapia, Victor	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
ABY897	Thomas, Donna	Uninsured Employer	1 day(s) jail 36 month(s) probation	$340	$80
M038060	Thomas, Sara	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,000	$120
M012001	Tobia, Mansour	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
M031112	Twist, Frank	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,000	$120
M015502	United Physicians, Multi Specialty Group	Uninsured Employer	36 month(s) probation	$2,500	$120
M044540	Urbina, Sandra	Uninsured Employer	1 day(s) jail Pled to Infraction		$100
M038054	Uriarte, Jose	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	$120
M004466	Villegas, Armando	Uninsured Employer	1 day(s) jail 36 month(s) probation	$3,000	$120
ABZ299	Waterman, Jay	Claimant Fraud	365 day(s) jail 60 month(s) probation 150 hour(s) community service	$20,805	$680

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Diego County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
ABZ685	Watson, Michael	Claimant Fraud	120 day(s) jail 60 month(s) probation	$13,088	$680
ABZ477	Webb, Mandy	Claimant Fraud	1 day(s) jail 36 month(s) probation 120 hour(s) community service	$4,514	$880
ACD562	West, Gene	Uninsured Employer	1 day(s) jail 36 month(s) probation	$500	
ABZ054	Williams, Tommie	Premium Fraud	536 day(s) jail 60 month(s) probation	$21,758	$880
M013658	Winn, Carol	Uninsured Employer	Sent. pending	$20,000	
M014236	Yacoubian, Vartan	Uninsured Employer	1 day(s) jail 36 month(s) probation	$9,000	$120
M031111	Yermian, Jackob	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120
ABY256	Young, Shirley	Claimant Fraud	180 day(s) jail 36 month(s) probation 80 hour(s) community service	$7,729	$260
M044546	Zapata, Erasmo	Uninsured Employer	1 day(s) jail 36 month(s) probation	$2,500	$120
M014152	Zepeda, Eduardo	Uninsured Employer	1 day(s) jail 36 month(s) probation	$1,500	$120

San Mateo County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
SM 352418	Folua, Isileil	Uninsured Employer	18 month(s) probation		$301
SC063199	Giron, Rudy	Claimant Fraud	180 day(s) jail 36 month(s) probation	$25,000	$275

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

San Mateo County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
SM352415	Guzman, Jose	Uninsured Employer	18 month(s) probation		$301
SC063083	Guzman, Maria	Insider Fraud	240 day(s) jail 60 month(s) probation	$22,000	$220
SM352417	Jildeh, Hanna	Uninsured Employer	18 month(s) probation		$301
SM352422	Ortiz, Joaquin	Uninsured Employer	18 month(s) probation		$301
SM352420	Revuelta, Luis	Uninsured Employer	18 month(s) probation		$301
SM352423	Sanchez, David	Claimant Fraud	18 month(s) probation		$301
SM352421	Vilchez, Jose	Uninsured Employer	18 month(s) probation		$301
SM352419	Wilson, Andrew	Uninsured Employer	18 month(s) probation		$301
SM352416	Won, Doo	Uninsured Employer	18 month(s) probation		$301

Santa Barbara County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
1182142	Ryles, Euell Bertram / Law Intake Corporation	Uninsured Employer	108 month(s) prison	$451	$10,000
1182142	Ryles, Linda Marie / Law Intake Corporation	Uninsured Employer	90 day(s) jail 60 month(s) probation	$800	$10,038

Santa Clara County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
CC893787	Alfaro, Timoteo Valencia	Uninsured Employer			$110
CC759628	Boyd, Randall Kevin	Claimant Fraud	365 day(s) jail 60 month(s) probation		
CC643901	Brunetti, Richard George	Premium Fraud	90 day(s) jail 36 month(s) probation	$121,749	$220
CC763291	Dasilva, Luis	Claimant Fraud	120 day(s) jail 18 month(s) probation	$13,000	$220

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Santa Clara County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
CC788439	Hernandez, Miguel	Other	365 day(s) jail 36 month(s) probation		
CC788439	Hernandez, Regina	Other	24 day(s) jail 36 month(s) probation		$365
CC788439	Hopkins, Deemone	Other	16 month(s) prison	$253	$256
CC894499	Hussain, Akber Ali	Uninsured Employer	12 month(s) probation		$365
CC775911	Ignacio, Josel Rustia	Uninsured Employer	12 month(s) probation		
CC768423	Munoz, Jose Anthony	Claimant Fraud	24 month(s) prison	$32,390	$400
CC763293	Nguyen, Truc	Claimant Fraud	120 day(s) jail 18 month(s) probation	$36,478	$220
CC893367	Patel, Parul	Uninsured Employer	12 month(s) probation		$365
CC788255	Pena Sr., James Anthony	Uninsured Employer	24 month(s) probation		$110
CC788253	Rivera, Ezequeil	Uninsured Employer	24 month(s) probation		$110
CC761684	Rodriguez, Ronald	Claimant Fraud	6 day(s) jail 60 month(s) probation	$27,117	$220
CC763292	Spangler, Alice Jean	Claimant Fraud	2 day(s) jail 36 month(s) probation	$2,486	
CC788257	Tonna, Robert John	Uninsured Employer	24 month(s) probation		$110
CC775910	Torrez Guzman, Jose Juan	Uninsured Employer	12 month(s) probation		$110
CC763271	Varda, Joseph	Premium Fraud	36 month(s) probation		$110

Santa Cruz County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
	Robinson, Patrick	Uninsured Employer	24 month(s) probation	$100	$500
	Rodriguez, Juan	Uninsured Employer	24 month(s) probation	$100	$500

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Santa Cruz County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
	Turner, Harold	Claimant Fraud	24 month(s) probation	$100	$500
	Zambrano, Jose	Uninsured Employer	24 month(s) probation	$100	$500

Shasta County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
06-4825	Dickens, Corey Earl / N/a	Claimant Fraud	1 day(s) jail 36 month(s) probation 480 hour(s) community service	$5,552	$3,143
06-2812	Michael, Lembo George / George Michaels Plumbing	Uninsured Employer	10 day(s) jail 36 month(s) probation 160 hour(s) community service		$2,423

Solano County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
FCR204874	Abeyta, John	Claimant Fraud	92 month(s) prison	$20,000	
FCR245646	Keller, Christopher	Claimant Fraud	36 month(s) probation		$1,000
FCR251340	Naranjo, Jesus / J&n Auto Body	Uninsured Employer	1 day(s) jail 24 month(s) probation		$750
FCR238755	Silva, Ismael	Uninsured Employer			$1,000

Sonoma County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
SCR 489422	Brabetz, Diane Coalla / Brabetz, Inc. / At Home Nursing Registry	Uninsured Employer	24 month(s) probation 40 hour(s) community service		$120

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Sonoma County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
SCR 509096	Cano, Juanita Julie	Claimant Fraud	24 month(s) probation 100 hour(s) community service	$1,694	$794
SCR 518652	Khoury, Jalil Hanna	Uninsured Employer	12 month(s) probation	$100	$400
SCR 518651	Shaw, Sanjib	Uninsured Employer	Probation denied		$300
SCR 524736	Tausch, Lawrence Michael	Uninsured Employer	12 month(s) probation		$10,220

Tulare County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
06-06454	Castillo, Jesus	Claimant Fraud	1 day(s) jail		
DCM138682	Chatten, Missie	Claimant Fraud	365 day(s) jail 36 month(s) probation	$60,760	
07022513	Flores, Javier Jaime	Premium Fraud	90 day(s) jail 36 month(s) probation		$1,000
07022513	Flores, Ramon Javier	Premium Fraud	30 day(s) jail 36 month(s) probation		$130
07-010658	Grantham, Stephanie	Claimant Fraud	90 day(s) jail 36 month(s) probation	$15,567	$1,000
06-003516	Heinrichs, Darrell	Uninsured Employer	60 day(s) jail 36 month(s) probation		
F-03-75211	Houts, George	Claimant Fraud	145 day(s) jail 60 month(s) probation	$15,000	$200
07026735	Mcdowell, Ronald	Uninsured Employer	30 day(s) jail 36 month(s) probation		
07-016401	Phillips, Brian	Claimant Fraud	200 day(s) jail 48 month(s) probation	$15,700	
06-06954	Phillips, Valorie	Claimant Fraud	120 day(s) jail 24 month(s) probation	$8,000	$500

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Tulare County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
07-017060	Torgeson, Harvey	Uninsured Employer	24 month(s) probation 100 hour(s) community service		$130
06-001344	Wheeler, David	Claimant Fraud	2 day(s) jail 36 month(s) probation		$110
08FW002801	Young, Otis	Uninsured Employer	90 day(s) jail 36 month(s) probation		$2,070

Ventura County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
2007010059	Aguilar, Abel Chacon	Claimant Fraud	30 day(s) jail 36 month(s) probation	$13,366	$100
2007036731	Bergin, Thomas	Uninsured Employer			$500
2007029067	Caputa, Jorge	Uninsured Employer	24 month(s) probation		$10,000
2008008053	Carbajal, Benjamin	Uninsured Employer	24 month(s) probation		$10,000
2007049686	Damian, Maria	Claimant Fraud	24 month(s) probation		$10,000
2008003572	Deardorff, James	Uninsured Employer	24 month(s) probation		$10,000
2006014079	Eiselle, Alexandra	Claimant Fraud	180 day(s) jail	$40,572	
2008008193	Estrada, Dennis	Uninsured Employer	24 month(s) probation		$10,000
2007038376	Gonzalez, Epifanio	Uninsured Employer	24 month(s) probation		$10,000
2007029500	Grove, Joy	Uninsured Employer	24 month(s) probation		$10,000
2005012101	Khalib, Josef	Premium Fraud	240 day(s) jail 36 month(s) probation	$28,596	$487
2008005583	Kraszewski, Larry	Uninsured Employer	24 month(s) probation		$10,000
2008008050	Layman, Daniel	Uninsured Employer	24 month(s) probation		$10,000

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Ventura County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
2008008039	Lopez, Jesus	Uninsured Employer	24 month(s) probation		$10,000
2005012101	Native Engineering	Premium Fraud	60 month(s) probation	$28,596	$487
2008008044	Ochoa, Delfino	Claimant Fraud	24 month(s) probation		$10,000
2007035232	Ochoa, Maria	Uninsured Employer			$10,000
2007005850	Reynolds, Larry	Uninsured Employer	36 month(s) probation		$10,000
2007013890	Ringleb, Sharon	Claimant Fraud	36 month(s) probation 120 hour(s) community service	$500	
2005012101	Rotholz, Tomer	Premium Fraud	24 month(s) prison 36 month(s) probation	$330,900	$400
2007011727	Salazar, Lidia	Claimant Fraud	120 day(s) jail 60 month(s) probation	$25,889	$287
2008008051	Sepidehdam, Mohamad	Uninsured Employer	24 month(s) probation		$10,000
2007013367	Soto, Jorge	Claimant Fraud	30 day(s) jail 36 month(s) probation	$7,315	$387
2005012101	Tapuz Enteprises	Premium Fraud	60 month(s) probation	$13,090	

Yolo County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
05SWC023	Backhaus, Adella / Cliff's Auto Center And Wrecking	Claimant Fraud	12 month(s) probation		$500
02SWC122	Banderas, Sara / Yolo Employment Services	Claimant Fraud	180 day(s) jail 36 month(s) probation	$21,500	
06SWC037	Fuller, Kelli Renee / Spa Central	Uninsured Employer	24 month(s) probation	$125	$8,033
03SWC003	Griffin, Guy / Distribution Inc.	Claimant Fraud	Pending restitution and sentencing		

Appendix # 6: Workers' Compensation Fraud Convictions (Fiscal Year 2007- 08) (continued)

Yolo County

Case Number	Subject Name	Role	Sentence	Restitution	Criminal
07SPN099	Mora, Alejandro Alex / General Climate Systems	Claimant Fraud		$48,500	
03SWC005	Rose, Bryan / United Parcel Services	Claimant Fraud	300 day(s) jail 60 month(s) probation	$20,951	$2,005
02SWC101	Walsh, Norma / Target Corp.	Claimant Fraud	45 day(s) jail 60 month(s) probation		

Appendix 7a: Arrest-Prosecution Summary - Part One

COUNTY	ARRESTS		PROSECUTIONS			CONVICTIONS	
	Felony	Misdemeanor	Cases	Suspects	Total Chargeable	Felony	Misdemeanor
Alameda	12	3	58	65	$3,193,477	12	8
Amador	2	3	12	14	$40,000	1	9
Butte	4	10	11	11	$0	0	2
Contra Costa	2	15	35	36	$382,719	2	18
El Dorado	11	19	56	56	$200,000	5	11
Fresno	0	0	31	41	$3,764,962	0	0
Imperial	1	0	7	7	$446,363	5	0
Kern	4	9	13	15	$2,830,849	2	9
Kings	0	5	6	6	$0	0	6
Los Angeles	72	33	146	180	$22,226,965	37	36
Marin	0	0	3	3	$58,781	0	0
Merced	1	1	6	18	$1,073,066	4	2
Monterey	1	1	6	8	$149,490	1	9
Orange	12	22	50	61	$106,889,465	8	21
Riverside	6	21	41	44	$9,337,019	3	25
Sacramento	13	14	46	50	$3,850,109	7	17
San Bernardino	5	20	77	96	$52,611,500	17	24
San Diego	51	72	230	230	$16,353,614	49	69
San Francisco	3	0	14	14	$1,263,462	1	3
San Joaquin	6	1	18	27	$37,413,985	4	4
San Luis Obispo	0	1	3	3	$0	1	1
San Mateo	3	1	15	15	$198,571	2	9
Santa Barbara	0	2	5	6	$0	2	0
Santa Clara	37	18	53	67	$5,750,724	12	15
Santa Cruz	0	3	16	12	$8,000	0	4
Shasta	0	0	5	5	$9,386	1	1
Siskiyou	0	0	1	1	$217,000	0	0

Appendix 7a: Arrest-Prosecution Summary - Part One (continued)

COUNTY	ARRESTS		PROSECUTIONS			CONVICTIONS	
	Felony	Misdemeanor	Cases	Suspects	Total Chargeable	Felony	Misdemeanor
Solano	4	3	11	11	$265,000	1	3
Sonoma	2	3	14	13	$158,261	1	3
Stanislaus	1	0	1	1	$0	0	0
Tulare	7	12	18	20	$113,363	5	6
Tuolumne	0	0	0	0	$0	0	0
Ventura	4	21	36	43	$1,400,070	9	15
Yolo	0	6	19	17	$259,033	1	4
TOTAL	**264**	**319**	**1063**	**1196**	**$270,465,234**	**193**	**334**

Appendix 7b: Arrest-Prosecution Summary - Part Two

COUNTY	PENALTIES		RESTITUTION		SEARCH WARRANTS	
	Ordered	Collected	Ordered	Collected	Search Warrants Issued	Number of Suspects
Alameda	$11,250	$5,750	$413,185	$271,518	0	0
Amador	$32,425	$21,860	$60,877	$3,488	1	2
Butte	$12,020	$0	$100	$0	0	0
Contra Costa	$27,469	$15,865	$125,289	$27,813	3	3
El Dorado	$36,695	$3,835	$0	$0	0	0
Fresno	$1,660	$1,660	$2,447,582	$721,381	2	8
Imperial	$0	$0	$252,431	$0	2	2
Kern	$10,265	$0	$818,118	$415,000	54	56
Kings	$1,800	$1,800	$0	$0	10	8
Los Angeles	$88,633	$7,975	$8,158,386	$1,225,438	8	9
Marin	$800	$800	$32,009	$32,009	0	0
Merced	$3,392	$770	$254,130	$1,460	0	0
Monterey	$5,870	$535	$184,498	$21,950	2	3
Orange	$101,500	$900	$838,603	$107,663	5	7
Riverside	$46,428	$46,428	$10,048	$6,250	17	11
Sacramento	$8,168	$1,865	$144,298	$43,110	0	0
San Bernardino	$44,988	$14,775	$2,097,118	$332,285	6	10
San Diego	$22,093	$0	$4,125,163	$5,084,748	69	25
San Francisco	$2,900	$0	$971,898	$28,398	4	4
San Joaquin	$2,100	$930	$2,012,441	$1,557,336	5	4
San Luis Obispo	$373	$0	$33,091	$0	0	0
San Mateo	$3,204	$2,332	$50,055	$23,000	0	0
Santa Barbara	$0	$0	$0	$0	0	0
Santa Clara	$2,781	$1,338	$201,082	$177,090	3	5
Santa Cruz	$2,560	$2,560	$5,600	$5,600	0	0
Shasta	$6,576	$0	$5,552	$0	4	2
Siskiyou	$0	$0	$0	$0	0	0

Appendix 7b: Arrest-Prosecution Summary - Part Two (continued)

COUNTY	PENALTIES		RESTITUTION		SEARCH WARRANTS	
	Ordered	Collected	Ordered	Collected	Search Warrants Issued	Number of Suspects
Solano	$2,750	$2,750	$20,019	$0	1	1
Sonoma	$11,590	$0	$3,388	$0	0	0
Stanislaus	$0	$0	$0	$6,396	0	0
Tulare	$5,140	$720	$115,027	$16,150	0	0
Tuolumne	$0	$0	$0	$0	0	0
Ventura	$152,648	$2,660	$188,825	$204,935	0	0
Yolo	$10,538	$5,350	$42,451	$35,816	0	0
TOTAL	**$658,616**	**$143,458**	**$23,611,264**	**$10,348,834**	**196**	**160**

Appendix 7c: Investigations

County	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider Fraud	Uninsured Employer	Other	TOTAL
Alameda	171	9		2		11	11	**204**
Amador	53	13		1		19		**86**
Butte	10	2				5	4	**21**
Contra Costa	22	3		1		23	2	**51**
El Dorado	2	1				163	22	**188**
Fresno	32	11	1	2		12	5	**63**
Imperial	1	2	4					**7**
Kern	39	10	1	1		8	3	**62**
Kings	15	4	1			8		**28**
Los Angeles	104	25	4	5	1	300	6	**445**
Marin	26	3		3				**32**
Merced	23	2	1					**26**
Monterey	20		2			4	11	**37**
Orange	74	20	25		2	54	5	**180**
Riverside	57	36		5		20	1	**119**
Sacramento	43	2				11	1	**57**
San Bernardino	93	12		7		39	1	**152**
San Diego	288	64	13	34	1	133	1	**534**
San Francisco	30			4	5			**39**
San Joaquin	36	3	3	2		11		**55**
San Luis Obispo	1						1	**2**
San Mateo	33							**33**
Santa Barbara	13			2		16	2	**33**
Santa Clara	30	17	1	1		27	5	**81**
Santa Cruz						14		**14**
Shasta	19	4		1		4		**28**
Siskiyou	2							**2**
Solano	26				1	4		**31**
Sonoma	5	1		1		1		**8**
Stanislaus	33						9	**42**
Tulare	20	3				15	1	**39**
Tuolumne	2							**2**
Ventura	20	7		1	1	22		**51**
Yolo	10	1				21	1	**33**
TOTAL	**1,353**	**255**	**56**	**73**	**11**	**945**	**92**	**2,785**

Appendix 8a: Standard Cases in Court

County	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider Fraud	Uninsured Employment	Other	Sub-Total
Alameda	23			2		12	3	**38**
Amador	1	1				6		**8**
Butte	1					2	5	**8**
Contra Costa	5					22		**27**
El Dorado	2					22	32	**56**
Fresno	2							**2**
Imperial	1							**1**
Kern	1	1				8		**10**
Kings						6		**6**
Los Angeles	11			1		35		**47**
Marin								**0**
Merced	1							**1**
Monterey	3						1	**4**
Orange	1					29		**30**
Riverside	9					24		**33**
Sacramento	11	1				15	1	**28**
San Bernardino	5					22		**27**
San Diego	31					129		**160**
San Francisco	11							**11**
San Joaquin	6							**6**
San Luis Obispo	2			1				**4**
San Mateo	1					10		**11**
Santa Barbara						3	1	**4**
Santa Clara	19	1				19	1	**40**
Santa Cruz	3					13		**16**
Shasta	2					3		**5**
Siskiyou	1							**1**
Solano				1		5		**6**
Sonoma	4					9		**13**
Stanislaus								**0**
Tulare	1					5		**6**
Tuolumne								**0**
Ventura	2					22		**24**
Yolo	1					13		**14**
TOTAL	**161**	**4**	**0**	**3**	**0**	**434**	**44**	**646**

Appendix 8b: Medium Cases in Court

County	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider Fraud	Uninsured Employment	Other	Sub-Total
Alameda	4						1	**5**
Amador	2							**2**
Butte						2		**2**
Contra Costa	3					2		**5**
El Dorado								**0**
Fresno	6					3		**9**
Imperial	2							**2**
Kern	1							**1**
Kings								**0**
Los Angeles	57	2	1					**60**
Marin								**0**
Merced							1	**1**
Monterey								**0**
Orange	10					1		**11**
Riverside	4	3						**7**
Sacramento	11	1						**12**
San Bernardino	25			1				**26**
San Diego	18	1		1		1	1	**22**
San Francisco								**0**
San Joaquin	1					2		**3**
San Luis Obispo								**0**
San Mateo	1	1			1			**3**
Santa Barbara								**0**
Santa Clara	1	2					1	**4**
Santa Cruz								**0**
Shasta								**0**
Siskiyou								**0**
Solano	2							**2**
Sonoma								**0**
Stanislaus								**0**
Tulare	6	1				2	1	**10**
Tuolumne								**0**
Ventura	6						1	**7**
Yolo	4						1	**5**
TOTAL	**164**	**11**	**1**	**2**	**1**	**13**	**7**	**199**

Appendix 8c: Complex Cases in Court

County	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider Fraud	Uninsured Employment	Other	Sub-Total
Alameda	6	2					3	**11**
Amador								**0**
Butte						1		**1**
Contra Costa	2							**2**
El Dorado								**0**
Fresno	6	2				5		**13**
Imperial	4							**4**
Kern								**0**
Kings								**0**
Los Angeles	20	5			1		1	**27**
Marin								**0**
Merced								**0**
Monterey			1			1		**2**
Orange	1	1	2					**4**
Riverside								**0**
Sacramento	4	1						**5**
San Bernardino	11	10		1				**22**
San Diego	5	8				1		**14**
San Francisco		1		2				**3**
San Joaquin	3					1		**4**
San Luis Obispo								**0**
San Mateo								**0**
Santa Barbara						1		**1**
Santa Clara		4					3	**7**
Santa Cruz								**0**
Shasta								**0**
Siskiyou								**0**
Solano	3							**3**
Sonoma		1						**1**
Stanislaus								**0**
Tulare						2		**2**
Tuolumne								**0**
Ventura	3							**3**
Yolo								**0**
TOTAL	**68**	**35**	**3**	**3**	**1**	**12**	**7**	**129**

Appendix 8d: Very Complex Cases in Court

County	Claimant Fraud	Premium Fraud	Multiple Entities Provider Fraud	Single Entity Provider Fraud	Insider Fraud	Uninsured Employment	Other	Sub-Total
Alameda		2					2	**4**
Amador	1	1						**2**
Butte								**0**
Contra Costa	1							**1**
El Dorado								**0**
Fresno	3	4						**7**
Imperial								**0**
Kern		1					1	**2**
Kings								**0**
Los Angeles	2	8	1		1			**12**
Marin	3							**3**
Merced		2	1				1	**4**
Monterey								**0**
Orange		3	1		1			**5**
Riverside		1						**1**
Sacramento		1						**1**
San Bernardino		2						**2**
San Diego	2	26				6		**34**
San Francisco								**0**
San Joaquin		2	3					**5**
San Luis Obispo								**0**
San Mateo	1							**1**
Santa Barbara								**0**
Santa Clara		2						**2**
Santa Cruz								**0**
Shasta								**0**
Siskiyou								**0**
Solano								**0**
Sonoma								**0**
Stanislaus	1							**1**
Tulare								**2**
Tuolumne								**0**
Ventura		2						**2**
Yolo								**0**
TOTAL	**14**	**57**	**6**	**0**	**2**	**6**	**4**	**89**

Appendix 8e: Cases in Court – Prosecuting Caseload

COUNTY	Total Cases	Total Defendants	Total Chargeable Fraud
Alameda	58	65	$3,193,477
Amador	12	14	$40,000
Butte	11	11	$0
Contra Costa	35	36	$382,719
El Dorado	56	56	$200,000
Fresno	31	41	$3,764,962
Imperial	7	7	$446,363
Kern	13	15	$2,830,849
Kings	6	6	$0
Los Angeles	146	180	$22,226,965
Marin	3	3	$58,781
Merced	6	18	$1,073,066
Monterey	6	8	$149,490
Orange	50	61	$106,889,465
Riverside	41	44	$9,337,019
Sacramento	46	50	$3,850,109
San Bernardino	77	96	$52,611,500
San Diego	230	230	$16,353,614
San Francisco	14	14	$1,263,462
San Joaquin	18	27	$37,413,985
San Luis Obispo	3	3	$0
San Mateo	15	15	$198,571
Santa Barbara	5	6	$0
Santa Clara	53	67	$5,750,724
Santa Cruz	16	12	$8,000
Shasta	5	5	$9,386
Siskiyou	1	1	$217,000
Solano	11	11	$265,000
Sonoma	14	13	$158,261
Stanislaus	1	1	$0
Tulare	18	20	$113,363
Tuolumne	0	0	$0
Ventura	36	43	$1,400,070
Yolo	19	17	$259,033
TOTAL	**1,063**	**1,196**	**$270,465,234**

Appendix 9a: 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	1	2		**3**	6		3	**9**	7	9		**16**	7	2	3	**12**
Amador	3	1	1	**5**	2			**2**	4	4		**8**	5			**5**
Butte				**0**				**0**	2			**2**	1	1		**2**
Contra Costa	17	2		**19**	1		1	**2**	2	10	2	**14**				**0**
El Dorado	4	17		**21**		2		**2**		17		**17**				**0**
Fresno		1		**1**	3			**3**				**0**		3		**3**
Imperial	3			**3**				**0**				**0**	1			**1**
Kern				**0**				**0**				**0**				**0**
Kings		5		**5**				**0**				**0**				**0**
Los Angeles	4	13	1	**18**	58	37	41	**136**	3	1		**4**	18	20	20	**58**
Marin		6	1	**7**		3	2	**5**				**0**				**0**
Merced				**0**	5	1		**6**		1		**1**	7			**7**
Monterey				**0**	1	1		**2**				**0**	5	2		**7**
Orange				**0**	15		5	**20**	2	2		**4**	22	5	21	**48**
Riverside	4	2		**6**	7		2	**9**				**0**	5	1		**6**
Sacramento	1	19	4	**24**			7	**7**		2	2	**4**		2	10	**12**
San Bernardino		7	2	**9**		1	9	**10**				**0**	6	7	8	**21**
San Diego		8		**8**		10		**10**		25		**25**				**0**
San Francisco				**0**				**0**				**0**				**0**
San Joaquin				**0**				**0**				**0**				**0**
San Luis Obispo				**0**				**0**				**0**				**0**
San Mateo		12	1	**13**	1	2	3	**6**				**0**	1	5	3	**9**
Santa Barbara		1		**1**		1		**1**				**0**				**0**
Santa Clara		1		**1**	7	11	9	**27**	1	2		**3**		1	2	**3**
Santa Cruz		6	4	**10**		3	3	**6**		26		**26**				**0**
Shasta		1		**1**		14		**14**		2		**2**		4		**4**
Siskiyou				**0**				**0**				**0**				**0**
Solano		9		**9**		14		**14**		1		**1**		3		**3**
Sonoma	2	1		**3**	1	1	2	**4**				**0**				**0**
Stanislaus				**0**			1	**1**				**0**				**0**
Tulare		1		**1**		6		**6**		23		**23**		4		**4**
Tuolumne				**0**				**0**				**0**				**0**

P: Pending **A**: Accepted **R**: Rejected **S-T**: Sub-total

Appendix 9a: Case Referrals – Part One (continued)

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
Ventura			1	**1**		6	3	**9**			1	**1**	5	2	5	**12**
Yolo	1	2		**3**		1		**1**	3	9	3	**15**	3			**3**
TOTAL	**40**	**117**	**15**	**172**	**107**	**114**	**91**	**312**	**24**	**134**	**8**	**166**	**86**	**62**	**72**	**220**

P: Pending **A**: Accepted **R**: Rejected **S-T**: Sub-total

Appendix 9b: 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				**0**	9	4		**13**	30	17	6	**53**
Amador				**0**	3		2	**5**	17	5	3	**25**
Butte	1	3		**4**	4	7	2	**13**	8	11	2	**21**
Contra Costa	1	1		**2**				**0**	21	13	3	**37**
El Dorado				**0**		41		**41**	4	77	0	**81**
Fresno				**0**	1		1	**2**	4	4	1	**9**
Imperial				**0**				**0**	4	0	0	**4**
Kern				**0**				**0**	0	0	0	**0**
Kings				**0**		2		**2**	0	7	0	**7**
Los Angeles				**0**	8	303	68	**379**	91	374	130	**595**
Marin				**0**		2		**2**	0	11	3	**14**
Merced				**0**		1		**1**	12	3	0	**15**
Monterey	2	1		**3**	2		1	**3**	10	4	1	**15**
Orange	1	5		**6**	7		4	**11**	47	12	30	**89**
Riverside				**0**	8	2		**10**	24	5	2	**31**
Sacramento		2	2	**4**			14	**14**	1	25	39	**65**
San Bernardino				**0**		2	2	**4**	6	17	21	**44**
San Diego				**0**				**0**	0	43	0	**43**
San Francisco				**0**				**0**	0	0	0	**0**
San Joaquin				**0**				**0**	0	0	0	**0**
San Luis Obispo				**0**				**0**	0	0	0	**0**
San Mateo				**0**				**0**	2	19	7	**28**
Santa Barbara		1		**1**		1		**1**	0	4	0	**4**
Santa Clara				**0**		1	1	**2**	8	16	12	**36**
Santa Cruz				**0**				**0**	0	35	7	**42**
Shasta				**0**		1		**1**	0	22	0	**22**
Siskiyou				**0**				**0**	0	0	0	**0**
Solano		2		**2**		2		**2**	0	31	0	**31**
Sonoma		1		**1**				**0**	3	3	2	**8**
Stanislaus				**0**				**0**	0	0	1	**1**
Tulare		1		**1**		4		**4**	0	39	0	**39**
Tuolumne				**0**				**0**	0	0	0	**0**

P: Pending **A**: Accepted **R**: Rejected **S-T**: Sub-total

Appendix 9b: Case Referrals – Part Two (continued)

County	Department of Industrial Relations				Others				Total			
	P	A	R	S-T	P	A	R	S-T	P	A	R	S-T
Ventura				**0**	5	4	6	**15**	10	12	16	**38**
Yolo		1		**1**	4	2	1	**7**	11	15	4	**30**
TOTAL	**5**	**18**	**2**	**25**	**51**	**379**	**102**	**532**	**313**	**824**	**290**	**1,427**

P: Pending **A**: Accepted **R**: Rejected **S-T**: Sub-total

Appendix 10: Press Clippings for Fiscal Year 2007- 2008

PRESS CLIPPINGS

Insurance Commissioner Poizner Announces Conviction of Workers' Compensation Insurance Fraud Perpetrator ..... August 27, 2007

Rialto Man Suspected of Insurance Fraud ..... September 21, 2007

2 Plead Guilty to Felony Insurance Fraud ..... September 22, 2007

Woman Convicted of Fraud..... November 7, 2007

Charges Added in Workers' Compensation Fraud Case..... November 17, 2007

Ex-Guard Guilty of Faking Injuries ..... December 4, 2007

Two Ventura County, Calif., Men Convicted of Workers' Comp Fraud..... December 5, 2007

California State Fund Receives $153,000 in Fraud Case..... December 10, 2007

Raley's Managers Withhold Workers' Compensation Claims..... December 18, 2007

Stockton Contractor Must Pay $2M to Fraud Victims ..... January 31, 2008

Insurance Scam Artists Targeted in Three Calif. Fraud Cases ..... February 8, 2008

Woman Sentenced in Fraud..... February 9, 2008

CDI Halts Alleged Fraud Schemes..... February 12, 2008

Mysterious Folder Cracked Workers' Comp Fraud Case ..... February 13, 2008

Family Members Charged with Insurance Fraud..... February 21, 2008

California Correctional Officer Arrested for Fraud ..... March 12, 2008

Former Riverside Officer Found Guilty of Fraud..... March 12, 2008

Beer Delivery Man Jailed for False Injury Claims..... March 27, 2008

Insurance Agent Charged with Defrauding Business Owners Out of More than $2.5 Million in Insurance Premiums ..... April 23, 2008

Doctor Arrested on Suspicion of Workers' Compensation Fraud ..... May 29, 2008

Chatsworth Flooring Company Agrees to Repay Millions in Workers' Comp Insurance Fraud Case ..... June 2, 2008

SoCal Man Sentenced in Insurance Fraud Case ..... June 2, 2008

Ione Prison Guard Faked Workers' Comp Injuries ..... June 26, 2008

Attorney, Accountant Charged in Alleged Insurance Scam at Buena Park Surgery Center ..... June 28, 2008

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FINANCIAL SURVEILLANCE BRANCH

FINANCIAL SURVEILLANCE BRANCH

The Financial Surveillance Branch (FSB) is responsible for monitoring the financial condition 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.

In November 2008, the California Department of Insurance was re-accredited by the National Association of Insurance Commissioners (NAIC) for a five-year period. Accreditation by the NAIC signifies that the financial surveillance performed by the FSB meets all of the financial solvency oversight standards established by the NAIC.

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 comprehensive 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 insurance management, operations, investments and advertising.

The AO oversees the determination of company reserves, reviews life insurance and annuity policy forms, and health insurance rates.

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 2008

Financial Statements Analysis	Annual Statement	Quarterly Statement
Life and Property & Casualty	576	1,060
Other Entities	347	290
Surplus Lines	106	318

Corporate Affairs Applications	Number of Applications
Certificate of Authority	58
Holding Company Matters	360
All Others	164

FIELD EXAMINATION DIVISION

Under the provisions of Section 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. In addition, FED provides financial and actuarial support to other divisions.

Various types of examinations initiated and completed by FED in 2008 are presented as follows:

Type of Examinations	Initiated	Completed
Domestic Companies	42	51
Underwritten Title Companies	24	14
Foreign Companies	5	4
Qualifying Exams	2	2
Statutory Exams	1	0
Total:	74	71

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; review life insurance and annuity policy forms; and reviews Medicare supplement and other accident & health insurance rate filings. 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
Asset Adequacy Analysis Memorandum	88
Life Insurance and Annuity Policy Forms	927

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 2008 on business done during 2007, other than retaliatory and surplus line taxes, amounted to $1,996,381,161. Refunds of $72,069,498 were granted during the year.

Additional assessments proposed by the Insurance Commissioner to the Board of Equalization and the State Controller's Office totaled $21,168,922.

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 2008 on business done during 2007 totaled $3,573,159.

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 2008 for calendar year 2007 totaled $173,307,062.

2008 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.

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: 2008

In 2008 the Auto Enforcement Bureau conducted twenty-five (25) administrative hearings to conclusion.

Monetary penalties and costs obtained through negotiated settlements and/or hearings totaled approximately $2,670,600.00.

175 matters opened
218 matters closed

Matter Type	Matters Opened	Matters Closed
Disciplinary	116	110
Vehicle Service Contract	1	4
Unfair Practices Act	10	3
Legal Opinion	8	6
Legislation(analysis of pending bill)	7	13
Miscellaneous	3	7
Human Resources	5	5
Regulation	4	1
Cease and Desist	0	2
Noncompliance	1	1
Litigation	2	4
Order to Show Cause	17	62
Oversight	1	0
Total	**175**	**218**

SIGNIFICANT MATTERS - AUTO ENFORCEMENT BUREAU 2008

1. Firestorm 2007 Underinsurance Issues
   -meetings with insurers
   -preparation of enforcement actions (ultimately not issued)

2. General Counsel's Legal Opinion - Regarding the right of a policyholder to replace his or her home (i.e. move) rather than rebuild per IC 2051.5.

3. One-on-one meetings with victims of the San Diego and Lake Arrowhead firestorms.

4. American Bankers settlement - $750,000.00.

   This matter is comprised of two files
   - a Market Conduct Exam ('04-'05 adopted '06) and
   - a FRUB Exam (2002).

   In the Market Conduct exam, we reviewed 357 files and found 172 violations (Approx. 50% error ratio). Two previous exams resulted in significant fines and had repeat violations. The FRUB exam uncovered a significant number of violations (27 general practices in violation of 43 total codes or regulations), including using unfiled rates on some policies. The Company also improperly placed policyholders in higher rated companies without considering the companies with lower rates and used inconsistent methods to evaluate dwelling values.

5. Mercury Insurance Company – Continued with administrative prosecution of Mercury insurers for rate law violation and deceptive advertising.

6. Vehicle service contract enforcement – Filed pleadings against several unlicensed VSC companies and the individuals and dealers that aided and abetted them.

7. AB 2150 – Worked with stakeholders to draft regulation to implement new law requiring approval of designations used in selling insurance to senior citizens.

CORPORATE AFFAIRS BUREAUS - I and II

Application Type	Beginning # Assigned Cases	Assigned	Closed	Ending # Assigned Cases
Amended Certificate of Authority	5	0	1	4
Approved of Trust	8	5	7	6
C/A Amend-Add Line	11	23	14	20
C/A Amend/Delete Line	1	3	4	0
C/A Amend-Domestic Change 70	3	3	4	2
C/A Amend-Name	14	23	29	8
C/A Amend-Non-Domestic Redo	8	14	15	7
Certificate of Authority	15	23	26	12
Certificate of Authority-Status – 7	29	13	11	31
Custodian Qualification	1	2	1	2
Custody Agreement	4	0	1	3
Exemption -Certificate of	6	0	1	5
Failure to Make Required Filing	3	26	26	3
Grants/Annuities - C/A	50	22	31	41
Grants/Annuities-Amended C/A	2	4	5	1
HC Disclaimer of Affiliation .41	6	10	6	10
HC Exempt - Comm Domiciled S	1	3	2	2
HC Exempt - form A.2f	2	16	13	5
HC Extraordinary Dividend .5g	1	39	33	7
HC Mtg. Serv./Cost Share Agmt.	126	159	125	160
HC Misc.	2	1	2	1
HC Ordinary Dividend .4f	4	67	71	0
HC Reinsurance .5b3	18	43	27	34
HC Sales Purchases Loans. 5b1	2	9	6	5
Holding Companies Acquisition	4	20	16	8
Letter of Credit	0	8	8	0
Merger	7	27	16	18
Miscellaneous	16	31	30	17
Motor Club License	2	1	1	2
Motor Club Service Contract	7	4	7	4
Name Approval Reservation	30	94	107	17
Organizational Permit	7	2	4	5
Reinsurance/Sale-Purchase/Transfer of Assets	28	25	30	23
Reinsurer Accreditation	31	32	31	32
Risk Purchasing Group	5	43	31	17
Risk Purchasing Group Renewal	4	239	228	15
Risk Retention Group	21	8	19	10
Risk Retention Group Renewal	44	119	101	62

CORPORATE AFFAIRS BUREAUS- I and II (continued)

Application Type	Beginning # Assigned Cases	Assigned	Closed	Ending # Assigned Cases
S810	2	0	0	2
Stock Permit	2	4	2	4
Stock Permit-Amend	0	1	1	0
Surplus Line Filing	45	10	31	24
UTC-Amended License	6	11	13	4
UTC-License	0	3	1	2
UTC-Organizational Permit	2	0	2	0
UTC-Permit	0	1	1	0
UTC-Transfer of Shares	9	5	12	2
Viatical Settlement Contract License	0	3	0	3
Viatical Settlement Provider	0	1	0	1
WC Deposit Agreement	2	5	6	1
Withdrawal	6	9	6	9
Total	**602**	**1214**	**1165**	**651**

ENFORCEMENT BUREAU – SACRAMENTO

New cases received: 1317
Closed/disposed: 1307

CONSENT: 263

Cease and Desist…….2

Order for Monetary Penalty and or/Reimbursement……..……2

Order of Immediate Suspension……5

Order Removing Restrictions…….……29

Miscellaneous Orders……..……63

Order of Dismissal/Application Withdrawn……..1

Order for Monetary Penalty in Lieu of Suspension…….....……0

Order of Denial……..……..……..70

Order of Denial/Issuance of Restricted License…….……..66

Order of Revocation…….……...…..4

Order of Revocation/Issuance of Restricted License…….....……7

Order of Dismissal/Surrender of License…….…….……..1

Order of Dismissal…….…….…….…...3

DEFAULT: 81

Order of Revocation…….……..…43

Order of Denial…….……..38

HEARING: 20

Order of Approval/Issuance…….....0

Miscellaneous…….….….…...0

Order of Denial…….……..…11

Order of Denial/Issuance of Restricted License……..……...…2

Order of Revocation…….…...3

Order of Revocation/Issuance of Restricted License……....3

Order of Dismissal…….……..……1

INFORMAL ACTION: 237

Warning…….….…..3

Voluntary Withdrawal of Application…….….…..0

Voluntary Surrender of License…….….…..0

No Disciplinary Action Warranted/Out of License…….….……0

No Disciplinary Action Warranted……..……40

No AR Action/Referred to Discip……..……181

Miscellaneous…….……..…....13

SUMMARY: 380

Order of Summary Denial……..…...181

Order of Summary Denial/Issuance of Restricted License…….…....115

Order of Summary Revocation……...…….….…82

Order of Summary Revocation/Issuance of Restricted License…….….…..2

LEGAL OPINION: 19

Closed cases…….…….……...…...19

ENFORCEMENT BUREAU – SAN FRANCISCO

During the year, 157 cases were received and action was completed on 227.

Order of Revocation……..…..…13

Order of Revocation/Issuance of Restricted License …….…...……..22

Order of Denial……..…10

Order of Denial/Issuance of Restricted License..……...…….…4

Order of Immediate Suspension…….……0

Order of Suspension…….……...……3

Order of Monetary Penalty &/or Reimbursement……..……..……9

Order of Dismissal……...……3

Order Removing Restrictions…….…..……..2

Miscellaneous Orders……...……..…56

No Disciplinary Action Warranted…….……...…27

Warning……..….…….….4

Order of Summary Revocation…….……..…...8

Order to Cease & Desist……...…..7

Enforcement Actions:

Unfair Practices Act Violations: (Monetary Penalties)

California Automobile Insurance Company,
Mercury Casualty Company,
Mercury Insurance Company……...…….……$250,000.00

Health Net Life Insurance Company…….….$3,600,000.00

Bankers Surety Services, Inc.…….…..$30,000.00

Lexington National Insurance Corp……..…….…..…$25,000.00

Allianz Life Insurance Co. of North America…….…...$3,000,000.00

Walf, Jermeny Alexander…….……..….$5,000.00

Schumann, Edward Michael…….…..$2,500.00

Prager, Judy Cheryl aka Prager, Judy Needleman……..$60,000.00

Title Insurance Violations:

LandAmerica Ins. Group
Commonwealth Land Title Company,
Lawyers Title Insurance Corp., Transnation Title
Company…….……..$3,500,000.00

Cease and Desist Orders:

Action International Insurance

Action Bail Bonds

American Staff Resources

Curco

Homeward Bound Services, Inc.

LL Roberts Group

Secure Care

FRAUD LIAISON BUREAU

The Fraud Liaison Bureau (FLB) provides legal support to the Department's Fraud Division (FD), a division of the Enforcement Branch. The FD maintains nine (9) regional offices throughout the state. It consists of more than 200 peace officers supported by approximately 50 staff personnel. The FD's mission is to suppress the overall incidence of insurance fraud within the state. The FD police officers investigate cases of suspected insurance fraud and present these cases to the local district attorneys in the counties in which the alleged fraud occurred.

Funding for the criminal prosecution of insurance fraud cases is provided via various grant programs to the counties whose district attorney offices have been awarded grants. The grants provide the financial resources to the office to assign prosecutors to prosecute these insurance fraud cases. The FD investigates and submits cases to the district attorneys office. Thereafter the district attorney determines if the evidence will support a criminal prosecution of the case.

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. It includes the promulgation of regulations, drafting of proposed legislation, and advice regarding the application of the California Insurance Code to the grant programs. The attorneys work with regional office fraud investigators on issues of subpoenas, search warrants, and other matters arising in the course of an investigation. Staff attorneys handle all requests for informal, and formal, legal assistance arising within the division's executive and regional administration.

Fraud Division Programs

1. Workers' Compensation Insurance Fraud Program - FD receives mandated funding under the CIC through the Fraud Assessment Commission (FAC) for the prevention of workers compensation insurance fraud within the state. The FAC is a legislatively created state body involved in assessing and administering a special fund dedicated to the investigation and prosecution of workers' compensation insurance fraud. The special fund is derived from an annual assessment upon employers within the state who provide their employees with mandated workers compensation insurance.

This special fund is used to provide individual grant programs to a large number of county district attorneys offices to fund the prosecution of workers compensation insurance fraud cases. The FAC, along with the Insurance Commissioner, and another, independent state body, the FAC Review Panel, are responsible for managing the Workers Compensation Insurance Fraud (WCIF) program.

Funding of the grant programs is maintained on a fiscal years basis. In fiscal year 2008/09 the FAC awarded $49,559,268.00 for the WCIF program. This amount is allocated between the FD and the various county District Attorneys (DAs). The DAs were awarded $28,995,240.00 total for all county grants. The FD was awarded $20,284,268.00 for administration and investigation of these cases; $200,000.00 for incidentals, and $75,000 for the Department of Industrial Relations workers compensation notification process. Thirty-six counties participated in this program. The FAC makes a recommendation for funding levels to the Insurance Commissioner. The Commissioner thereafter authorizes the funding distribution levels. Annual audits of the services rendered by each local DAs office are conducted by FD, with legal support. One full time senior staff counsel is assigned to this program.

The duties of staff counsel include advice to senior management of the FD and the FAC commissioners related to the operations of the grant programs, the requirements of public hearings on decisions made by the FAC, as well as review of the numerous legal documents that arise in the course of the administration of the program, and the interpretation of code sections and regulations that pertain to the grant process.

2. Automobile Insurance Fraud Section 1872.8 CIC - The FD coordinates automobile insurance fraud investigations statewide, provides assistance to law enforcement agencies, and presents prosecutable automobile fraud cases to district attorney's offices. The fiscal year budget for 2008-09 is $34,646,000. The FD is allocated $21,595,000.00 and the DAs (aka "local assistance") the sum of $13,051,000.00. Thirty-four counties participated in this program. Fraudulent activity includes medical mills, organized crime staged accident rings, paper accidents, and organized car theft conspiracies, as some of the enforcement targets pursued.

3. Organized Automobile Insurance Fraud Activity Interdiction Program - Legislative findings confirm that 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 grants in the amount of $5,784,756.00 for fiscal year 2008/2009 for a coordinated program targeted at the prosecution and elimination of organized automobile insurance fraud. Task forces have been established throughout the state comprised of FD personnel, CHP, district attorneys offices and allied agencies.

4. Underground Economy Task Force - The Task Force has the general purpose of coordinating enforcement activities and sharing information for combating tax evasion problems and the failure to pay wages that are legally due. It is comprised of representatives from the Employment Development Department, Department of Consumer Affairs, DIR, and Office of Criminal Justice Planning, and other prospective agencies.

5. Property/Casualty/Life Program - This program includes all criminal cases of fraudulent claims arising from all lines of insurance other than auto and workers' compensation. Funding for this program is derived from an annual assessment per licensed insurance company. Criminal cases are presented to both state and federal prosecutors.

6. Disability Insurance Fraud Assessment Program covering Life and Disability Health Insurance. This grant program, like the others, is directed to the prevention of fraud in this area of insurance. Total funding for fiscal year 2008/09 is approximately $3.56 million: $1.853 million to FD, and $1.712 million for the five county district attorneys receiving grants.

7. 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.

8. Internal Affairs - The FLB provides legal advice & support to the FD Internal Affairs Unit which conducts confidential investigations of department employees allegedly engaged in some form of impermissible conduct during the course of their employment, or outside their employment which violates department policies, etc.

Legal Services for Program Funding and Support

Funding for all the above programs arise out of assessments upon various lines of insurance policies sold within the state by the insurance industry. The assessment process upon the insurance industry requires the promulgation and implementation of various sets of regulations through the Office of Administrative Law (OAL), and at times changes in legislation. FLB attorneys are assigned full time with the responsibility of reviewing, consulting, and drafting the regulations, and proposed legislation, in conjunction with the grant programs as requested by the division. Additionally, legal services include the writing of legal opinions, statutory review, and responses to outside counsel. They also provide general legal advice, attend public hearings, review pending legislation, and provide audit support.

Qui Tam Civil Actions

Qui tam cases are whistle-blower civil actions filed under the Insurance Frauds Prevention Act found in the California Insurance Code. These cases are filed in both state and federal court seeking millions of dollars in damages for the filing of false insurance claims. The parties involved can range from small auto body repair facilities to extremely large pharmaceutical companies submitting alleged fraudulent billing arising out of the miss-coding of claims, and overcharges for services and products. They usually are extremely large cases involving a number of attorneys and law firms. Usually, the "relator," or complainant is an insider working for the defendants.

The relator is often aliened with the insurance carrier that paid the false claims to the companies that overcharged for the goods and services submitted for payment to the carrier. These cases cover a large variety of conduct, including the submission of fraudulent insurance claims, misleading billing practices, and unwarranted services, etc.

Under the Insurance Code, the Insurance 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 or not. In 2008 the department received 17 new cases. These were added to the 44 pending qui tam cases already lodged with the Department. An attorney is assigned to review these cases, and make a recommendation to the Commissioner as to intervention in the matter or further handling. At times, the Commissioner will intervene in the case if a substantial public interest is involved.

Other Civil Actions

Lawsuits are periodically filed against the Department and the FD for conduct arising out of a fraud investigation. When this occurs, and FLB attorney is assigned to handle the matter and work with the Attorney General's Office to protect the interests of the Commissioner. Lawsuits can also take the form of a bankruptcy proceeding of a licensee of the Department such as a large underwritten title insurance company relating to mortgage insurance fraud. FLB attorneys handle these matters as well.

Legislative Analysis, Review, and Support

A number of bills requiring legal support in the promulgation of legislative changes, or attendance at hearings, are requested by the FD, and staff counsel handle these requests.

Insurance Fraud Advisory Board

One FLB attorney is assigned to this industry board which 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.

Anti-Fraud Taskforce Project

Two FLB attorneys were assigned to this major project in 2008 which resulted in the issuance of a report in May 2008: California Department of Insurance Advisory Task Force On Insurance Fraud—Reducing Insurance Fraud in California. Seventeen recommendations were made by the taskforce, most of which require legislative or regulatory changes to existing law.

The categories of cases handled by FLB in 2008 are described below.

Matter Type	Matters Opened	Matters Closed	Pending at Year End
Qui Tam Litigation	17	2	44
Legal Opinions	7	4	3
Legislation (analysis of pending bill)	5		5
Miscellaneous	3	3	0
Human Resources	2	1	1
Regulation	2	3	0
Civil Litigation	2	2	0
Subpoenas	4	4	0
Search Warrants	2	2	0
Oversight	7	4	3
Total	**51**	**21**	**54**

GOVERNMENT LAW BUREAU

Total cases opened 2008……...1,212

Public Records Act Request……...863

Subpoena……..217

Litigation-Defense……...……..49

Litigation-Qui Tam…….....17

Litigation-Appeal or Writ…….....17

Service of Process…….…..….47

Miscellaneous……...…….……2

Total cases closed 2008…….……1,184

Public Records Act Request……...…...868

Subpoena……..…….…....221

Litigation…….…….……...37

Litigation……..……6

Litigation……..……...14

Service of Process…….....37

Miscellaneous……..……1

The Government Law Bureau received $18,185.51 if payment of records provided related to subpoena and Public Record Act requests.

POLICY APPROVAL BUREAU

Product	Submissions	
	Received	Closed
Group Non-Health	318	220
Supplemental Life	170	123
Variable Contracts	429	310
Group & Individual Non-Health	518	498
Medicare Supplement	229	240
Unclassified	46	78
Individual Non-Health	67	76
Individual & Group Credit	24	15
Long Term Care	200	211
Workers Compensation	247	241
Sub-total	**2248**	**2012**
Variable Annuity -Amend	180	158
Variable Life -Amend	82	77
Variable Annuity	1	2
Variable Life	0	2
Modified Guarantee Annuity	0	1
Sub-total	**263**	**240**
Other Activities:		
Regulations	2	6
Legal Opinions	3	1
Legislation	27	21
Litigation	6	1
Miscellaneous	0	0
Subpoena	1	1
Others	0	0
Sub-total	**39**	**30**
TOTAL	**2550**	**2282**

The NAIC product coding matrix has been completed for PAB/Actuarial products and associated implementation documents have been provided to SERFF. SERFF staff will be building the California Life & Health "instance" during May.

On May 1 SERFF informed Bruce Hinze that the SERFF trainers will be contacting him regarding scheduling training. SERFF had been responding to inquiries regarding training scheduling during April with "we're working on it," or words to that effect. Now it appears that scheduling will proceed. Aside from scheduling training, we are still on track for June implementation. Also, 2 PAB staff members have been trained in document comparison using Adobe Acrobat, and will be training other PAB staff during May.

SERFF implementation status as of May 1:

The NAIC product coding matrix completed for PAB/Actuarial products and associated implementation documents have been provided to SERFF. SERFF staff will be building the California Life & Health "instance" during May.

SERFF informed Bruce Hinze today (May 1) that the SERFF trainers will be contacting him regarding scheduling training. SERFF had been responding to inquiries regarding training scheduling during April with "we're working on it," or words to that effect. Now it appears that scheduling will proceed.

Aside from scheduling training, we are still on track for June implementation.

Also, 2 PAB staff members have been trained in document comparison using Adobe Acrobat, and will be training other PAB staff during May.

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 Disaster 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.

Following hearings conducted in 2008, rate reductions totaling almost $540 million, and ranging from 15% to 28.5%, were ordered by the Commissioner.

Additionally, the Bureau reviews and approves vehicle service contract applications which comply with all applicable legal requirements.

A summary of the Bureau's major actions for 2008 is set forth below.

Prior Approval

Petitions for Hearing Received…… 24

Petitions for Hearing Granted…….0

Petitions for Hearing Denied……13

Notices of Hearing Issued……...2

Matters Resolved Without Hearing……3

Matters Resolved Following Hearing……4

Matters Pending……..13

Rollback

Administrative Cases Pending……1

Rollback Litigation Pending……1

Vehicle Service Contract

Applications Received……279

Applications Concluded……..225

Regulations

Regulation Matters Opened……...4

Regulations Approved……..…1

Civil Litigation

Matters Opened……2

Matters Closed……..2

Matters Pending……2

CAARP

Appeals Opened……...0

Appeals Resolved……2

Producer Peer Review Matters Opened……...2

Producer Peer Review Decisions Issued……..2

Servicing Carrier Applications Received……...5

Servicing Carrier Applications Approved……..4

Servicing Carrier Applications Denied……..1

Section 674.6 Notices

Matters Opened……1

Matters Pending……1

2008 ANNUAL REPORT

LEGISLATIVE OFFICE

LEGISLATIVE OFFICE

The Department of Insurance's (CDI) 2008 legislative agenda focused on promoting efficiency and cost savings in CDI business operations and aligning various California insurance statutes with National Association of Insurance Commissioners (NAIC) standards. Two CDI-sponsored measures exemplifying this effort, as well as supporting objectives on Commissioner Poizner's Strategic Plan (CDI to operate as paperless as possible, utilize electronic-based media whenever feasible, and increase consumer awareness through its public website) are Senate Bill 1279 and Assembly Bill 2044.

SB 1279 (Maldonado, Chapter 351, Statutes 2008) removed statutory barriers preventing CDI from eliminating wasteful paper-driven business processes. The bill authorized the Department to maintain records in electronic form and to handle transactions electronically, including accepting electronic signatures on Department records. It also provided for CDI to post specified bail and surety informational lists on its website; previously, CDI had to mail the lists in paper format to all 58 counties in California. Lastly, the bill eliminated the statutory requirements for insurers doing business in California to submit specified documents in paper in triplicate, resulting in savings to both insurers and CDI.

AB 2044 (Duvall, Chapter 300, Statutes 2008) established a citation and fine program for minor violations of the Insurance Code. Under prior law, CDI had three options for minor breaches: formal legal action, verbal or written warning, or no action. The citation program enhances CDI's ability to enforce minor insurance-related infractions and saves time and money by providing an alternative to pursuing minor violations through the courts. The bill also made minor changes to the Insurance Code to unify California law with NAIC rules and the laws of other states including increasing continued education requirements for specified licensees and to eliminate the examination requirement for a California nonresident licensee seeking a California resident license under specified conditions.

In 2008, the Legislative Office (LO) conducted a comprehensive review of its business processes and determined it was fiscally and operationally advantageous to convert to an electronic bill file maintenance system, as opposed to hard copy, paper versions. Effective with the 2009-10 Legislative Session, the LO implemented an electronic bill analysis filing system and procedures. Also in 2008, the LO provided several training sessions on completing bill analyses to Department staff in Sacramento, San Francisco and Los Angeles.

2008 ANNUAL REPORT

POLICY AND REGULATIONS BRANCH

POLICY AND REGULATIONS BRANCH

The Policy and Regulations Branch includes: the Special Projects Division, Policy Research Division, and the Statistical Analysis Division. The Special Projects Division supports the Commissioner's Executive Team in identifying and analyzing emerging insurance issues with policy implications. The unit also assists with implementing appropriate Commissioner-directed policy initiatives, through coordination of department wide task forces. The Policy Research Division and Statistical Analysis Division conduct data calls mandated by statute and regulation, and at the direction of the Executive Team, pursue research on targeted questions. These units identify and measure trends in the industry in order to support the Commissioner's decisionmaking process. By integrating policy development, planning and research, the Policy and Regulations helps solve significant problems faced by consumers, industry stakeholders, and responds to the needs of the Governor and Legislature in a coordinated, efficient fashion.

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 2008, the Policy Research Division’s most important activities included:

- Continued technical support for implementation of the RH03029826 regulations, the revised auto rating factor regulations (Title 10, Section 2632.8)
- Completion of the 2008 California Private Passenger Auto Frequency and Severity Bands Manual and a technical report
- Technical and administrative support for an analysis of alternatives to reinsurance for the California Earthquake Authority.
- Quantitative analysis of the regulatory change from 10 claim frequency and claim severity bands to 20 bands for auto insurance.

SPECIAL PROJECTS DIVISION

The Special Projects Division (SPD) supports the Commissioner’s policy ideas and initiatives by performing targeted research, analysis, and development, managing certain communications, and expediting regulations.

Research assignments completed in 2008 included compiling a report card on the major lines of insurance (auto, home and life), consolidating information about preparing for and mitigating the effects of catastrophes (wildfire, earthquake, flood), and substantiating the improving trends in both the Workers’ Compensation market and the battle to protect consumers from insurance fraud of all kinds from 2000 to 2007 in California.

The SPD assists 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 (meeting synopsis reports, conference notebooks, surveys) between the CDI and the NAIC.

The SPD produces the Commissioner's Annual Report. On behalf of the Policy & Regulations Branch (PRB), the SPD communicates with and contributes to the following ongoing department-wide efforts: Green Team, Disability Advisory Committee (DAC), Web Content Management Group, Enterprise Information Project Users Group, and the internet and intranet redesign projects.

The SPD helps CDI regulations navigate the Administrative Procedure Act's adopt, amend and repeal processes, as administered by the Office of Administrative Law. The SPD offers clerical assistance to the team leads of current rulemaking projects, such as setting up the Pre-Notice Public Discussion or subsequent hearing and researching factual issues. In 2008, the CDI received approval on or filed with the Secretary of State 12 rulemaking projects. As of December 31, 2008, the CDI listed 41 current rulemaking projects and 9 prospective rulemaking projects. The SPD also compiles the CDI 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 to support a healthy insurance marketplace and provide 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 2008, 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.
- Insurance policies for the Slavery Era Insurance Policy Registry, as required by California Insurance Code Sections 13810-13813.
- 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.
- Workers Compensation Policyholder Appeal public contact data by company under California Code of Regulations Title 10, Chapter 5, Section 2509.43.
- 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.
- Commissioner's Report of 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 & 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 & Report Development, in accordance with California Insurance Code Section 1872.85.
- Health Assessment Table & 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 & Report Development, in accordance with California Insurance Code Section 1872.86.
- Bureau of Fraudulent Claims Table & Report Development, in accordance with California Insurance Code Section 1874.8.

The SAD conducted several management-requested data collections during the year which supported long term insurance data trend analysis. In addition, SAD provided Private Passenger Automobile and Personal Property information to the National Association of Insurance Commissioners (NAIC) for their annual reports.

2. SPECIAL PROJECTS REQUESTED BY EXECUTIVE STAFF/COMMISSIONER:

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

- Workers Compensation Claims Adjuster, Medical-Only Claims Adjuster and Medical Bill Reviewer Data Call – Data was collected for experienced and non-experienced categories for the 2008 reporting year. In addition to the data collected, SAD had also developed a database to help stakeholders review and analyze the individual company information.
- Designated Office of Consumer Appeals for Workers Compensation – Provided the Commissioner, Office of the Ombudsman and Legal Division with designated contact information by company pursuant to California Code of Regulations Title 10, Chapter 5, Section 2509.43.
- Language Assistance Program Implementation & Compliance – Per California Insurance Codes (CIC) 10133.8 and 10133.9, and Title 10, California Code of Regulations (CCR) 2538.1 – 2538.8. , every California Health Insurer is required to implement a Language Assistance Program to provide language assistance services (interpretation and translation) to their limited-English proficient insured. In cooperation with the California Department of Insurance's Legal Division, the Statistical Analysis Division had developed the LAP-2008 Data Call, statistical plan website, related processes and procedures to assist in monitoring compliance from companies.
- Angora and Southern CA Fires – Provided the Commissioner, Press Office, Consumer Services, and Financial Analysis Division with reports showing loss data resulting from the firestorms that affected CA in 2007 and 2008.

3. RESEARCH CONSULTATION/DATABASE DEVELOPMENT:

At various times throughout the year, the SAD provides technical assistance in developing databases or assistance in conducting analyses of data for CDI internal branches as well as other state agencies.

The following is a list of the SAD's research consultation/database development activities during 2008:

- 1998 – 2007 Long-Term Care Insurance Experience data – Responded to a request for data from the California Dept of Health Services (Partnership for LTC Division).
- Language Assistance Program Implementation & Enforcement – In response to a request from Legal Division, SAD was asked to develop a report database to assist in their analysis of the individual company form filings. SAD senior staff worked with attorneys from Legal Division to create an interactive database that improved access and review of data and the ability to develop summary reports of the file review process.
- Automobile Rating Factors – Continued to provide data from our private passenger automobile liability database to CDI Policy Research Division, working with outside consultants, to conduct a study for the development of new automobile rating factors in compliance with Prop 103.
- Fraud Vehicle Assessment – Provide CDI Accounting staff with private passenger automobile exposure database for audit purposes in regards to the Fraud Vehicle Assessment payments from insurers (California Insurance Code 1872.8).
- Report Card (Strategic Plan 1.4) – Assisted and provided data in the development of an insurance "report card" for each major line of insurance in order to assess the level of competition, establish a grading mechanism on financial soundness of an insurer, pricing and servicing levels.

4. REQUEST FOR DATA/CONSUMER INQUIRIES RECEIVED DURING CALENDAR YEAR 2008:

During calendar year 2008, the SAD had been requested to provide data and handle inquiries received by the CDI's Consumer Hotline. With respect to data requests, the SAD fielded requests for data from a wide spectrum of the public – from individual consumers, to other state and federal agencies, to university students and professors. The following is a list of some of the many public agencies, consumer groups and other entities that have requested data or assistance from SAD:

- Association of California Life & Health Insurance Companies
- California Automobile Assigned Risk Plan (CAARP)
- California Earthquake Authority (CEA)
- California Health Benefits Review Program
- California Partnership for Long-Term Care
- Commission on Health and Safety and Workers' Compensation
- Insurance Committee – California Legislature
- Department of Finance
- San Francisco Department of Parking and Traffic

- Texas Legislative Council
- Insurance Services Office (ISO)
- John Hancock Insurance Companies
- Aon Benfield Risk Management Company
- Mercury Insurance Company
- Los Angeles Times
- New York Times
- Office of United States Congressman Henry Waxman
- Other State Insurance Agencies
- Red Cross
- Senate Office of Research
- University of California Los Angeles
- University of Southern California
- University of California Berkeley
- Various Consumer Groups
- Various Insurance Industry Trade Groups
- Wall Street Journal

2008 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 2008, the percentage of total filings received through SERFF increased to seventy nine percent (79%), up from fifty one percent (51%) in 2007.

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 mandates 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 2008, five hundred thirty six (536) 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 2007, eighty eight (88) 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 2008	2008	2007
Private Passenger Automobile	753	485
Homeowners	289	206
Other Personal Lines Products	362	488
Title	88	137
Workers Compensation	536	594
Medical Malpractice	51	110
Other Commercial Lines Products	6268	4523
Total	**8347**	**6543**

RATE SPECIALIST BUREAU (RSB)

The Rate Specialist Bureau (RSB) provides technical advice and support to the Insurance Commissioner, executive staff, and other CDI Branch Managers 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 2008.

1. During 2008, RSB worked with the Title Insurance Working Group in dealing with the proposed Title Insurance regulation. RSB took on the major responsibility of revising the Statistical Plan for submittal to the Office of Administrative Law for approval.

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 Rate-of-Returns; Projected Yields; Investment Income; CPI Index for expense trend factors; the Federal Income Tax rate on investment income; California and Countrywide Profitability; and Risk Based Capital.
3. RSB conducted a special Survey of Marketing System Information to collect data in order to update the calculation of efficiency standards. The new refined survey will become an annual data call.
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 Statute 199, 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 2007.
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 2008.

Per CIC §674.5 & §674.6:

PRIOR WITHDRAWAL & CEASE-WRITING NOTICES RECEIVED BY THE INSURANCE COMMISSIONER DURING 2008

NAIC#	Company Name	Group Name	Request Date	Effective Date	Proposed Action by Company
27073	Nipponkoa Insurance Company Ltd, U.S. Branch	Nipponkoa Ins. Co. Ltd.	01/04/2008	04/04/2008	Cease writing personal lines business.
20486	Transcontinental Insurance Company	CNA Insurance Group	01/04/2008	01/31/2007	Merged with & into National Fire Ins. Co. of Hartford (NAIC # 20478) - merged among affiliates.
14133	Valley Insurance Company	Unitrin Group	02/01/2008		Withdraw from the following lines of business: commercial property, standard commercial auto, commercial general liability, commercial package, commercial umbrella, workers' comp, inland marine, farm/ ranchowner insurance business and policies.
21407	Emcasco Insurance Company	EMC Insurance Group	03/24/2008	07/02/2008	Withdrawal from personal lines business. Lines to be withdrawn are: fire, marine, automobile, liability.
21405	Employers Mutual Casualty Company	EMC Insurance Group	03/24/2008	07/02/2008	Withdrawal from personal lines business. Lines to be withdrawn are: fire, marine, automobile, liability.
35769	Lyndon Property Insurance Company	Protective Life Ins Grp	06/03/2008		Withdraw Single Premium Mortgage Involuntary Unemployment Insurance program. The program is no longer being used.
42048	Diamond State Insurance Company	United National Group	06/13/2008	08/20/2008	Discontinue writing the Standard Insurance Agents Professional Liability Program.
42048	Diamond State Insurance Company	United National Group	07/23/2008		Discontinue writing its program for bicycle manufacturers, dealers and rental operations
41181	Universal Underwriters Insurance Company	Zurich Insurance Group	07/28/2008		Non-renewal of its agricultural equipment program property and casualty coverage

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 2007, 23 property-casualty companies/groups admitted to do business in California submitted data under CIC §1864 requirements. Of the 23 insurers, 17 insurers submitted data for FDC Homes insured either on a separate liability policy or as an endorsement to the homeowners' policy. Sixteen (16) insurers submitted data for licensed CC Centers.

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

Of the 17 companies/groups reporting data for FDC Homes in 2007, 5 insurers had direct written premium exceeding $100,000. These 5 insurers provided coverage for 12,114 FDC Home providers, approximately 91% of all the FDC business insured. Of these 17 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 6 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			
	2006	2007	2006	% of Total	2007	% of Total
From 0 - 10 providers	7	6	21	0.16%	21	0.16%
From 11 - 100 providers	4	4	177	1.32%	191	1.44%
From 100 - 450 providers	3	1	1,071	7.97%	191	1.44%
Over 450 providers	5	6	12,175	90.56%	12,904	96.97%
TOTAL	19	17	13,444	100.00%	13,307	100.00%

**Note: 2006 data revised*

INSURERS REPORTING DATA FOR FAMILY DAY CARE HOMES: PART 2

	# of Companies Writing		# of FDC Homes (Providers) Insured			
	Calendar Year: 2006	Calendar Year: 2007	Calendar Year: 2006		Calendar Year: 2007	
Small FDC Homes (1-6 children)	15	14	9,753	72.55%	9,794	73.60%
Large FDC Homes (7-12 children)	10	9	3,691	27.45%	3,513	26.40%
Total Insurers Providing Coverage	19	17	13,444	100.00%	13,307	100.00%

Of the 17 insurers that wrote child care liability insurance for FDC Homes in 2007, 14 insurers wrote coverage for Small FDC Homes (licensed for 1 to 6 children) and 9 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 90.7% of all Small FDC Homes. Of the 9 Large FDC Home insurers, 2 insurers had direct written premium exceeding $100,000. They insured about 92.1% of all Large FDC Homes.

Policy Writing Activity: Child Care Centers (CC Centers)

Of the 16 companies/groups which submitted data for licensed Child Care Centers in 2007, 9 insurers had direct written premium exceeding $100,000. These 9 carriers insured approximately 93.0% of the CC Center business.

Of the 16 insurers submitting data, 4 carriers insured from 0 to 10 CC Centers each, 3 carriers insured between 11 and 50 CC Centers, 2 carriers insured between 51 and 200 CC Centers, and 7 insurers wrote more than 200 CC Centers in 2007.

INSURERS REPORTING DATA FOR CHILD CARE CENTERS

Range: Insured Count	# of Companies Writing		# of Child Care Centers Insured			
	2006	2007	2006		2007	
From 0 - 10	3	4	4	0.11%	11	0.33%
From 11 - 50	4	3	81	2.29%	41	1.22%
From 51 - 200	1	2	185	5.23%	391	11.65%
From 201+ providers	9	7	3,264	92.36%	2,913	86.80%
TOTAL	17	16	3,534	100.00%	3,356	100.00%

INSURERS' ACTIVITY IN 2007

From the information provided for calendar year 2007, there was a decrease 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: 2006	Calendar Year: 2007	Calendar Year: 2006	Calendar Year: 2007
# of Insurers Reporting Data	19	17	17	16
# of Policies In-Force at Beginning of Year*	13,215	12,076	2,797	2,941
# of Policies In-Force at End of Year*	12,912	12,252	3,246	2,770
Change in # Policies In-Force at End of Year	-2.29%	1.46%	16.05%	-5.81%
# Insurers w/ No Policies In-Force at End of Year	0	0	1	2

**Note: 2006 data revised.*

EXHIBIT II: Breakdown of Form and Coverage Types Written During 2006 and 2007

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

19 insurers reported data for calendar year 2006 / 17 insurers reported data for 2007

Family Day Care Homes:

FORM TYPE:	# of Companies Writing	
	2006	2007
○ Occurrence Policy	18	16
○ Claims-Made Policy	1	1
○ Both Occurrence & Claims-Made Policy	0	0
○ Not Specified	0	0

COVERAGE/LIMITS:	# of Companies Writing	
	2006	2007
○ 100/300 limit, OL&T	1	0
○ 300 CSL, OL&T	0	0
○ Endorsement to Homeowners Policy	8	6
○ From 100K/100K to 500K/500K	0	0
○ Up to $1 Mil+ CSL	5	5
○ Various Limits (from 100 CSL to 500 CSL)	0	0
○ 1Mil / All Other	4	3
○ Various - Not Specified	1	3

CHILD CARE CENTERS (Licensed for 13+ children)

17 insurers reported data for calendar year 2006 / 16 insurers reported data for 2007

Child Care Centers

FORM TYPE:	# of Companies Writing	
	2006	2007
○ Occurrence Policy	15	15
○ Claims-Made Policy	1	1
○ Both Occurrence & Claims-Made	1	0
○ Various ($1M/$1M; $1M/All Other; higher limits)	6	5
○ Various - Not Specified	2	2

Child Care Centers (continued)

COVERAGE/LIMITS:	# of Companies Writing	
	2006	2007
○ 100/300 limit, OL&T	1	1
○ 300 CSL, OL&T	1	1
○ Various Limits (below $1 Mil)	1	1
○ Various Limits (up to & above $1 Mil+ CSL)	6	6

EXHIBIT III: Insurers Reporting Child Care Data for Calendar Year 2006 vs. 2007 per CIC §1864

INSURERS REPORTING	CALENDAR YEAR 2006		CALENDAR YEAR 2007		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
California Casualty Insurance Cos.	X		X		OC
Church Mutual Insurance Co.	X	X	X	X	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	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		X	OC
Philadelphia Indemnity Insurance	X	X	X	X	OC
Riverport Insurance Co. of CA	X	X	X	X	OC
SAFECO Insurance Group	X	X	X	X	CL
State Farm Insurance Cos.	X	X	X	X	OC
St. Paul Travelers Group	X	X		X	OC
Stonington Insurance Co.	X	X	X	X	OC
TIG Insurance Group		X			OC
TOPA Insurance Company	X	X	X	X	OC
Unigard Insurance Group	X		X		OC
Zurich American Ins. Group		X		X	OC
# of Insurers Submitting Data	19	17	17	16	

Total number of Insurers Submitting Data for 2006 24

Total number of Insurers Submitting Data for 2007 23

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 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
# Insurers Reporting Data	19	17	17	16	24	23
1) Premiums Earned	$4,118,910	$4,223,315	$6,229,777	$4,806,986	$10,348,687	$9,030,301
2) Premiums Written	$4,510,058	$4,297,973	$5,756,661	$5,688,835	$10,266,719	$9,986,808

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 & CC Centers	
	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
3) Outstanding at Beginning of Year	90	38	154	73	244	111
4) New - During Reporting Period	92	136	173	192	265	328
5) Closed During Reporting Period	121	110	254	191	375	301
6) Outstanding at End of Year	61	64	73	74	134	138
7) Total Losses Incurred	$1,712,158	$607,952	$2,802,071	$2,806,716	$4,514,229	$3,414,668
8) Loss Ratio (7)/(1)	41.57%	14.40%	44.98%	58.39%	43.62%	37.81%
9) Loss Adjustment Expenses (LAE)	$622,365	$470,772	$555,655	$347,988	$1,178,020	$818,760
10) Total Losses Incurred + LAE	$2,334,523	$1,078,724	$3,357,726	$3,154,704	$5,692,249	$4,233,428
11) Loss & LAE Ratio (10)/(1)	56.68%	25.54%	53.90%	65.63%	55.00%	46.88%

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 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
12) In-Force at Beginning of Year	13,215	12,076	2,797	2,941	16,012	15,017
13) Written During the Year	4,623	4,114	952	623	5,575	4,737
14) Cancelled During the Year	1,294	614	304	275	1,598	889
15) NonRenewed During the Year	3,632	3,324	199	519	3,831	3,843

EXHIBIT IV (continued)

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

Number of Policies (continued):

	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 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
16) In-Force at End of Year	12,912	12,252	3,246	2,770	16,158	15,022

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 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
a. Commissions	$781,623	$818,063	$963,622	$751,829	$1,745,245	$1,569,892
b. Other Acquisition Costs	$219,372	$220,217	$370,434	$286,659	$589,806	$506,876
c. General Expenses	$194,066	$196,811	$262,639	$259,613	$456,705	$456,424
d. Taxes, Licenses, Fees	$109,442	$108,094	$152,024	$111,910	$261,466	$220,004
18) Total Underwriting Expenses	$1,304,503	$1,343,185	$1,748,719	$1,410,011	$3,053,222	$2,753,196
Total Expense Ratio [(18)/(1)]	31.67%	31.80%	28.07%	29.33%	29.50%	30.49%
19) Combined Loss & Expense Ratio	88.35%	57.35%	81.97%	94.96%	84.51%	77.37%
20) Net Underwriting Gain or (Loss) [(1)-(10)-(18)]	$479,884	$1,801,406	$1,123,332	$242,271	$1,603,216	$2,043,677
21) Allocated Investment Income/(Loss)	$281,800	$344,955	$390,355	$327,580	$672,155	$672,535
22) Net Income/(Loss) after Investment [(20)+(21)]	$761,684	$2,146,361	$1,513,687	$569,851	$2,275,371	$2,716,212

** 2006 Policy count was revised.*

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 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
# OF INSURERS REPORTING FDC INFO.	**15**	**14**	**10**	**9**
1) Premiums Earned	$1,830,354	$1,903,932	$2,288,556	$2,319,383
2) Premiums Written	$1,848,116	$1,924,831	$2,661,942	$2,373,142

Number of Claims:

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
3) Outstanding at Beginning of Year	43	16	47	22
4) New - During Reporting Period	38	43	54	93
5) Closed During Reporting Period	53	36	68	74
6) Outstanding at End of Year	28	23	33	41
7) Total Losses Incurred	$378,454	($304,598)	$1,333,704	$912,550
8) Loss Ratio (7)/(1)	20.68%	-16.00%	58.28%	39.34%
9) Loss Adjustment Expenses (LAE)	$283,203	$275,443	$339,162	$195,329
10) Total Losses Incurred + LAE	$661,657	($29,155)	$1,672,866	$1,107,879
11) Loss & LAE Ratio (10)/(1)	36.15%	-1.53%	73.10%	47.77%

Number of Policies:

	SMALL FDC HOMES Licensed for 1-6 Children		LARGE FDC HOMES Licensed for 7-12 Children	
	CALENDAR YEAR 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
12) In-Force at Beginning of Year	9,400	8,606	3,815	3,470
13) Written During the Year	3,716	3,442	907	672
14) Cancelled During the Year	668	470	626	144
15) NonRenewed During the Year	3,064	2,783	568	541
16) In-Force at End of Year	9,384	8,795	3,528	3,457

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 2006	CALENDAR YEAR 2007	CALENDAR YEAR 2006	CALENDAR YEAR 2007
a. Commissions	$310,067	$326,443	$471,556	$491,621
b. Other Acquisition Costs	$115,202	$118,916	$104,170	$101,301
c. General Expenses	$84,498	$76,789	$109,567	$120,021
d. Taxes, Licenses, Fees	$47,284	$48,381	$62,158	$59,713
18) Total Underwriting Expenses	$557,051	$570,529	$747,451	$772,656
Total Expense Ratio [(18)/(1)]	30.43%	29.97%	32.66%	33.31%
19) Combined Loss & Expense Ratio	66.58%	28.43%	105.76%	81.08%
20) Net Underwriting Gain or (Loss) [(1)-(10)-(18)]	$611,646	$1,362,558	($131,761)	$438,848
21) Allocated Investment Income/(Loss)	$130,553	$159,023	$151,247	$185,932
22) Net Income/(Loss) after Investment [(20)+(21)]	$742,199	$1,521,581	$19,486	$624,780

** 2006 Policy count was revised.*

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 2007. 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 HOMES & CHILD CARE CENTERS

Year	Small FDC Homes	Large FCD 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

** 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.

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 -- 2007

In October 2001, the Department resumed collecting the California Legal Professional Liability Insurance Report. 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 2008 reports is July 1, 2009, at the time this Commissioner's Report was prepared, the 2008 data was not yet submitted. The 2008 summary will be available in next year's report.

For 2007, 23 companies/groups reported data under this section. Nineteen (19) insurers reported writing claims-made policies, 3 wrote occurrence policies, and 1 wrote both.

Group/Company Name	Direct Written Premium	Direct Earned Premium	Direct Incurred Losses	Loss Ratio
2007: 23 Insurers Reporting	$203,624,753	$208,165,179	$101,161,637	48.60%
2006:* 21 Insurers Reporting	$217,884,554	$217,073,320	$100,477,149	46.29%

**Revised: 3/2009 – add 1 company's premium/losses.*

CALIFORNIA LEGAL PROFESSIONAL LIABILITY INSURANCE: Top 10 Writers – 2007

Group/Company Name	Market Share	Direct Written Premium	Direct Earned Premium	Direct Incurred Losses	Loss Ratio
1) Lawyers' Mutual Insurance Company	23.34%	$47,523,000	$50,055,000	$15,827,000	31.62%
2) CNA Insurance Group	17.21%	$35,038,596	$32,997,032	$27,256,378	82.60%
3) Arch Insurance Company	15.66%	$31,891,644	$32,567,236	$5,879,478	18.05%
4) Greenwich Insurance Company	10.27%	$20,912,012	$20,643,365	$10,871,521	52.66%
5) Carolina Casualty Insurance Company	8.54%	$17,385,561	$18,014,165	$14,513,388	80.57%
6) Chubb Group	8.25%	$16,801,179	$16,776,485	$5,386,477	32.11%
7) Zurich-U.S. Insurance Group	6.79%	$13,835,090	$14,573,651	$8,630,811	59.22%
8) Great American Insurance Company	3.21%	$6,540,748	$8,623,841	$1,915,075	22.21%
9) State National Insurance Company, Inc.	2.39%	$4,876,592	$4,821,477	$2,731,692	56.66%
10) Hartford Group (The)	1.67%	$3,407,837	$4,122,471	$207,485	5.03%
Top 10 Insurers	97.34%	$198,212,259	$203,194,723	$93,219,305	45.88%
GRAND TOTAL	**100.00%**	**$203,624,753**	**$208,165,179**	**$101,161,637**	**48.60%**

2007 LEGAL PROFESSIONAL LIABILITY REPORT: SUMMARY OF PREMIUMS & EXPENSES

Calendar Year	Total # of Lawyers Written during 2007 [1]	Direct Premiums Written [2]	Direct Premiums Earned [3]	Direct Losses Incurred [4]	Loss Ratio	DCCE Incurred [5]	Incurred Losses & DCCE Ratio [6]
2007	74,020	$203,624,753	$208,165,179	$101,161,637	48.60%	$49,962,891	72.60%
2006	73,797	$217,891,554	$217,073,320	$90,509,236	41.70%	$54,509,406	66.81%
2005	65,257	$213,667,974	$216,543,137	$74,969,316	34.62%	$42,467,938	54.23%

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]
2007	$8,788,465	$20,756,666	$3,181,459	$5,729,654	$7,610,187	$46,066,431	94.73%
2006	$9,081,141	$17,068,344	$3,447,484	$3,994,931	$10,067,491	$43,659,390	86.92%
2005	$8,806,582	$19,761,984	$3,744,651	$5,719,943	$11,833,165	$49,866,325	77.26%

Field Description & Calculations for 2007 Legal Professional Liability Report: Summary of Premiums & Expenses.

1 = Total number of Lawyers Written During 2007
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 & Defense & Cost Containment Expense 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 2007 – 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 *	1,298	$0	$0
$ 0 *	309	$0	$9,768,468
$ 1 - 9,999	56	$675	$1,295,118
$ 10,000 - 49,999	116	$2,913,243	$3,041,320
$ 50,000 - 99,999	88	$6,610,003	$3,581,340
$ 100,000 - 249,999	75	$11,485,618	$5,859,925
$ 250,000 - 499,999	38	$14,630,963	$2,884,414
$ 500,000 - 749,999	10	$5,534,050	$791,422
$ 750,000 - 999,999	6	$6,000,072	$330,185
$ 1,000,000 and over	12	$23,741,973	$2,969,822
TOTAL	2,008	$70,916,598	$30,522,015

Note (*): The claims closed in 2007, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses (DCCE) Paid and Claims without Defense and Cost Containment Expenses (DCCE) Paid.

CLAIMS CLOSED WITH PAYMENT TO THE CLAIMANT DURING 2007						
Occurrence Year	**# of Claims [1]**	**Total Monetary Amount Paid [2]**	**Average Claim Payment [3]**	**DCCE Paid [4]**	**Loss + DCCE Paid [5]**	**Average Loss & DCCE Paid [6]**
Pre 1999	18	$5,835,352	$324,186	$1,565,638	$7,400,990	$411,166
1999	5	$1,512,950	$302,590	$1,154,390	$2,667,340	$533,468
2000	10	$1,640,100	$164,010	$607,539	$2,247,639	$224,764
2001	19	$10,365,904	$545,574	$2,245,087	$12,610,991	$663,736
2002	29	$5,652,865	$194,926	$2,060,940	$7,713,804	$265,993
2003	45	$7,628,143	$169,514	$2,748,177	$10,376,320	$230,585
2004	71	$10,499,219	$147,876	$3,333,429	$13,832,648	$194,826
2005	100	$14,937,997	$149,380	$4,740,138	$19,678,135	$196,781
2006	81	$11,571,406	$142,857	$2,003,351	$13,574,757	$167,590
2007	17	$690,170	$40,598	$59,850	$750,020	$44,119
TOTAL	395	$70,334,107	$178,061	$20,518,539	$90,852,646	$230,007

Occurrence Year	**CLAIMS CLOSED WITHOUT PAYMENT TO THE CLAIMANT DURING 2007**			**All CLAIMS COMBINED**
	# of Claims [7]	**DCCE Paid [8]**	**Average DCCE Paid [9]**	**Average Claim Payments: ALL Claims [10]**
Pre 1999	33	$1,254,901	$38,027	$169,723
1999	15	$966,211	$64,414	$181,678
2000	13	$443,558	$34,120	$117,009
2001	27	$596,835	$22,105	$287,127
2002	64	$1,686,363	$26,349	$101,077
2003	179	$855,610	$4,780	$50,143
2004	278	$1,138,701	$4,096	$42,898
2005	360	$1,467,124	$4,075	$45,968
2006	368	$1,306,122	$3,549	$33,142
2007	225	$53,045	$236	$3,318
TOTAL	1,562	$9,768,470	$6,254	$51,416

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

Field Descriptions & Calculations for Claims Closed With & Without Payment to the Claimant During 2007 Data

1 = Number of Claims Closed With Payment
2 = Total Monetary Amount Paid
3 = Average Claim Payment (3 = 2/1)
4 = Defense & Cost Containment Expenses Paid With Payment
5 = Loss + Defense & Cost Containment Expense Paid (5 = 2 + 4)
6 = Average Loss & Defense & Cost Containment Expense Paid (6 = 5/1)
7 = Number of Claims Closed Without Payment
8 = Defense & Cost Containment Expenses Paid Without Payment
9 = Average Defense & Cost Containment Expense Paid (9 = 8/7)
10 = Average Claim Payments: All Claims (10 = [5 + 8]/[1 + 7])

Occurrence Year	CLAIMS REPORTED for FIRST TIME & REOPENED CLAIMS		CLAIMS OUTSTANDING as of 12/31/2007				MONETARY AMOUNT PAID ON CLAIMS DURING 2007	
	# of Claims Reported for 1st Time During 2007	# of Claims Re-Opened During 2007	# 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 1999	27	8	39	$1,576,027	$1,488,872	$495,582	$5,012,677	$2,123,526
1999	4	1	19	$1,532,986	$548,185	$497,802	$2,097,222	$1,657,827
2000	6	2	20	$2,598,574	$240,985	$1,027,196	$1,326,853	$1,165,083
2001	13	2	58	$3,912,721	$2,414,104	$2,413,936	$9,913,521	$4,180,565
2002	11	8	74	$6,100,897	$3,160,547	$2,087,094	$7,528,412	$9,386,242
2003	29	13	83	$14,012,534	$2,097,418	$7,595,107	$5,919,209	$2,892,963
2004	56	12	215	$11,735,534	$6,390,078	$11,528,187	$10,622,306	$9,863,068
2005	95	30	330	$16,927,740	$8,100,524	$20,324,637	$24,109,070	$13,487,167
2006	238	35	502	$13,991,096	$8,555,013	$41,040,096	$14,360,471	$8,382,857
2007	919	2	652	$10,908,429	$6,010,153	$55,634,680	$1,907,269	$1,723,314
TOTAL	1,398	113	1,992	$83,296,538	$39,005,879	$207,604,531	$82,797,011	$54,862,613

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

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE REPORT: 2007

In June 2003, the Department resumed collecting the California Medical Professional Liability Insurance Report. 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 2008 reports is July 1, 2009, at the time this Commissioner's Report was prepared, the 2008 data was still being submitted. The 2008 summary will be available in next year's report.

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2007
SUMMARY OF PREMIUMS AND EXPENSES

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

	2005	2006	2007
# of Providers/ Beds Insured *	270,972	274,171	355,126
Direct Premiums Written	$729,893,237	$732,378,917	$705,135,162
Direct Premiums Earned	$721,188,563	$713,215,072	$709,707,506
Direct Losses Incurred	$254,890,011	$214,151,048	$201,919,797
LOSS RATIO	**35.34%**	**30.03%**	**28.45%**
Defense & Cost Containment Exp Incurred (DCCE)	$217,351,054	$190,573,685	$167,602,873
INCURRED LOSS + DCCE RATIO	**65.48%**	**56.75%**	**52.07%**
Adjusting & Other Expenses Incurred	$75,548,638	$61,883,961	$56,018,421
Commissions & Brokerage Exp Incurred	$39,496,906	$42,277,092	$42,112,787
Taxes, Licenses & Fees Incurred	$18,100,858	$18,019,478	$17,197,504
Other Acquisitions, Field Supervision Expenses Incurred	$19,808,680	$21,374,695	$19,115,366
General Expenses Incurred	$57,810,173	$59,197,555	$56,412,707
Underwriting Expense	$210,765,255	$202,752,781	$190,856,785
COMBINED RATIO = (Loss + Expenses)/EP	**94.71%**	**85.17%**	**78.96%**

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

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2007

PHYSICIANS

	2005	2006	2007
# of Insurers Reporting Data	25	26	26
# Insurers Reporting w/ DWP > $0	18	21	20
# of Providers/ Beds Insured *	42,142[*1]	43,095[*2]	40,770[*2]
Direct Premiums Written	$593,309,432	$591,421,247	$569,312,479
Direct Premiums Earned	$580,693,405	$574,609,552	$576,106,793
Direct Losses Incurred	$197,142,101	$170,055,392	$167,138,424
LOSS RATIO	**33.95%**	**29.59%**	**29.01%**
Defense & Cost Containment Exp Incurred (DCCE)	$164,813,927	$161,080,993	$126,509,594
INCURRED LOSS + DCCE RATIO	**62.33%**	**57.63%**	**50.97%**
Adjusting & Other Expenses Incurred	$52,514,896	$60,854,198	$48,769,107
Commissions & Brokerage Exp Incurred	$22,686,574	$24,263,655	$28,195,564
Taxes, Licenses & Fees Incurred	$14,455,778	$14,206,908	$13,882,542
Other Acquisitions, Field Supervision Expenses Incurred	$15,665,600	$15,551,109	$14,617,897
General Expenses Incurred	$45,671,585	$46,678,187	$44,259,001
Underwriting Expense	$150,994,433	$161,554,058	$149,724,111
COMBINED RATIO = (Loss + Expenses)/EP	**88.33%**	**85.74%**	**76.96%**

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

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2007 (continued)

OTHER HEALTH CARE PROFESSIONALS

	2005	2006	2007
# of Insurers Reporting Data	19	18	13
# Insurers Reporting w/ DWP > $0	17	16	8
# of Providers/ Beds Insured *	164,151[*2]	172,903[*2]	276,488[*1]
Direct Premiums Written	$96,337,173	$101,330,573	$103,961,964
Direct Premiums Earned	$95,556,028	$99,135,980	$102,404,734
Direct Losses Incurred	$30,340,052	$23,350,698	$35,916,180
LOSS RATIO	**31.75%**	**23.55%**	**35.07%**
Defense & Cost Containment Exp Incurred (DCCE)	$25,091,003	$20,289,996	$31,514,938
INCURRED LOSS + DCCE RATIO	**58.01%**	**44.02%**	**65.85%**
Adjusting & Other Expenses Incurred	$9,095,692	$8,482,530	$4,157,706
Commissions & Brokerage Exp Incurred	$13,240,649	$14,357,395	$10,724,204
Taxes, Licenses & Fees Incurred	$2,619,210	$2,797,256	$2,642,379
Other Acquisitions, Field Supervision Expenses Incurred	$2,492,943	$4,604,601	$3,364,587
General Expenses Incurred	$9,239,750	$9,154,408	$10,209,892
Underwriting Expense	$36,688,244	$39,396,190	$31,098,769
COMBINED RATIO = (Loss + Expenses)/EP	**96.40%**	**83.76%**	**96.22%**

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

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2007 (continued)

HOSPITALS

	2005	2006	2007
# of Insurers Reporting Data	15	15	15
# Insurers Reporting w/ DWP > $0	9	6	7
# of Providers/ Beds Insured *	56,488*3	11,443*2	31,415*2
Direct Premiums Written	$26,938,233	$27,892,975	$21,587,864
Direct Premiums Earned	$29,461,840	$27,059,268	$20,560,100
Direct Losses Incurred	$25,942,870	$19,865,425	($4,754,488)
LOSS RATIO	**88.06%**	**73.41%**	**-23.12%**
Defense & Cost Containment Exp Incurred (DCCE)	$25,328,962	$4,592,275	$6,409,496
INCURRED LOSS + DCCE RATIO	**174.03%**	**90.39%**	**8.05%**
Adjusting & Other Expenses Incurred	$13,175,313	($8,011,653)	($1,628,923)
Commissions & Brokerage Expenses Incurred	$2,299,871	$2,676,656	$2,010,919
Taxes, Licenses & Fees Incurred	$714,673	$618,142	$387,464
Other Acquisitions, Field Supervision Expenses Incurred	$758,775	$534,780	$441,235
General Expenses Incurred	$1,737,746	$1,734,257	$1,429,246
Underwriting Expense	$18,686,378	($2,447,818)	$2,639,941
COMBINED RATIO = (Loss + Expenses)/EP	**237.45%**	**81.34%**	**20.89%**

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

CALIFORNIA MEDICAL PROFESSIONAL LIABILITY INSURANCE: REPORT YEAR 2007 (continued)

OTHER HEALTH CARE FACILITIES

	2005	2006	2007
# of Insurers Reporting Data	17	17	18
# Insurers Reporting w/ DWP > $0	9	10	8
# of Providers/ Beds Insured *	8,191 *1	46,730 *1	6,453 *1
Direct Premiums Written	$13,308,399	$11,734,122	$10,272,855
Direct Premiums Earned	$15,477,291	$12,410,272	$10,635,879
Direct Losses Incurred	$1,464,987	$879,533	$3,619,681
LOSS RATIO	**9.47%**	**7.09%**	**34.03%**
Defense & Cost Containment Expenses Incurred (DCCE)	$2,117,161	$4,610,420	$3,168,846
INCURRED LOSS + DCCE RATIO	**23.14%**	**44.24%**	**63.83%**
Adjusting & Other Exp Incurred	$762,736	$558,886	$4,720,530
Commissions & Brokerage Expenses Incurred	$1,269,812	$979,386	$1,182,099
Taxes, Licenses & Fees Incurred	$311,197	$397,172	$285,120
Other Acquisitions, Field Supervision Expenses Incurred	$891,363	$684,206	$691,647
General Expenses Incurred	$1,161,092	$1,630,702	$514,568
Underwriting Expense	$4,396,199	$4,250,352	$7,393,963
COMBINED RATIO = (Loss + Expenses)/EP	**51.55%**	**78.49%**	**133.35%**

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

The following exhibits show the total premiums and losses as reported by the insurers in their Annual Statements to the NAIC database under Line 11 – Medical Malpractice.

For 2008, 94 California licensed companies reported data under this line. Of this amount, 36 companies had Direct Written Premium greater than $0. Of these 36 companies, only 14 had Direct Written Premium greater than $5,000,000. The top 10 insurers for 2008 wrote approximately 92.5% of all California medical malpractice business written by licensed insurers.

California Medical Malpractice Liability Insurance
(Source: NAIC Database, as of 04/16/09)

	Year	Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct DCCE Incurred	Direct Losses Incurred + DCCE Incurred Ratio
36 Companies w/ DWP > $0	2008	$610,446,385	$611,448,969	$100,485,324	16.43%	$116,220,676	35.44%
Total Reporting: 94 Companies	2008	$610,392,276	$611,413,738	$89,471,925	14.63%	$116,796,715	33.74%
36 Companies w/ DWP > $0	2007	$639,699,856	$641,288,249	$192,509,258	30.02%	$151,468,319	53.64%
Total Reporting: 92 Companies	2007	$639,563,252	$641,259,093	$182,127,921	28.40%	$151,499,812	52.03%

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 DCCE Incurred	Direct Losses Incurred + DCCE Incurred Ratio
1	Norcal Mutual Insurance Company	$163,314,374	26.75%	$164,523,202	$30,028,405	18.25%	$36,842,463	40.65%
2	Doctors Company An Interinsurance Exchange	$151,261,024	24.78%	$148,456,629	$27,252,030	18.36%	$24,048,182	34.56%
3	SCPIE Indemnity Company	$87,751,988	14.38%	$87,885,453	$17,140,297	19.50%	$12,628,160	33.87%
4	Medical Ins. Exchange of California	$37,864,332	6.20%	$38,053,520	($3,879,058)	-10.19%	$5,020,629	3.00%
5	Dentists Insurance Company	$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 Indemnity Company	$25,983,208	4.26%	$28,228,538	$4,790,121	16.97%	$6,432,283	39.76%
8	National Union Fire Insurance Company of Pittsburg	$16,378,872	2.68%	$10,260,471	$6,722,314	65.52%	$2,119,340	86.17%
9	American Casualty Company of Reading	$14,923,219	2.44%	$14,875,230	$2,100,677	14.12%	$3,602,266	38.34%

TOP 10 MEDICAL PROFESSIONAL LIABILITY WRITERS IN CALIFORNIA: YEAR 2007

(Source: NAIC Database as of 3/25/08)

#	Company Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Direct DCCE Incurred	Direct Losses Incurred + DCCE Incurred Ratio
1	Norcal Mutual Ins Company	$172,895,826	27.03%	$171,121,113	$48,586,220	28.39%	$59,711,410	63.29%
2	Doctors Company an Interinsurance Exchange	$151,884,220	23.74%	$143,192,938	$44,512,622	31.09%	$20,255,444	45.23%
3	SCPIE Indemnity Company	$94,462,935	14.77%	$97,088,453	$31,971,468	32.93%	$16,237,800	49.65%
4	Medical Insurance Exchange of California	$38,196,755	5.97%	$35,560,607	($1,069,020)	-3.01%	$7,336,857	17.63%
5	American Healthcare Indemnity Company	$30,471,588	4.76%	$29,996,476	$3,627,698	12.09%	$4,698,243	27.76%
6	Medical Protective Company	$27,357,021	4.28%	$27,460,288	$13,502,719	49.17%	$4,530,539	65.67%
7	Dentists Insurance Company	$27,086,986	4.23%	$26,490,371	$7,806,818	29.47%	$7,774,036	58.82%
8	American Insurance Company	$19,441,500	3.04%	$19,085,487	$12,542,587	65.72%	$9,278,863	114.34%
9	American Casualty Company of Reading PA	$14,776,843	2.31%	$14,268,405	$5,318,802	37.28%	$4,382,622	67.99%
10	Health Providers Insurance Reciprocal, Risk Retention Group	$14,721,955	2.30%	$14,633,638	$14,041,654	95.95%	$3,868,028	122.39%
	Top 10 Med Mal Writers	$591,295,629	92.43%	$578,897,776	$180,841,568	31.24%	$138,073,842	55.09%

DISTRIBUTION BY SIZE OF PAYMENT FOR CLAIMS CLOSED DURING 2007

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)	4,677	$0	$88,596,326
$ 0 w/out DCCE (1)	2,815	$0	$0
$ 1 - 9,999	410	$1,818,269	$3,683,315
$ 10,000 - 49,999	472	$10,837,883	$17,019,500
$ 50,000 - 99,999	180	$11,046,421	$9,234,997
$ 100,000 - 249,999	261	$37,226,122	$17,157,203
$ 250,000 - 499,999	101	$31,710,490	$9,342,499
$ 500,000 - 749,999	30	$16,411,853	$3,257,773
$ 750,000 - 999,999	37	$30,740,532	$4,669,445
$ 1,000,000 and over	53	$74,447,200	$7,302,489
TOTAL	9,036	$214,238,771	$160,263,547

Notes: (1) The claims closed during 2007, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses (DCCE) Paid and "Claims without Defense & Cost Containment Expenses (DCCE) Paid."

DISTRIBUTION BY SIZE OF PAYMENT FOR CLAIMS CLOSED DURING 2007 (continued)

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)	3,834	$0	$74,488,186
$ 0 w/out DCCE (1)	2,233	$0	$0
$ 1 - 9,999	78	$353,529	$1,345,855
$ 10,000 - 49,999	267	$6,319,616	$11,847,524
$ 50,000 - 99,999	105	$5,759,549	$6,166,712
$ 100,000 - 249,999	203	$28,606,777	$13,593,288
$ 250,000 - 499,999	84	$26,720,870	$7,611,705
$ 500,000 - 749,999	26	$14,061,852	$2,848,717
$ 750,000 - 999,999	35	$28,875,532	$4,483,290
$ 1,000,000 and over	42	$57,205,000	$5,603,412
TOTAL	6,907	$167,902,726	$127,988,688

Notes: (1) The claims closed during 2007, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses (DCCE) Paid and "Claims without Defense & Cost Containment Expenses (DCCE) Paid."

DISTRIBUTION BY SIZE OF PAYMENT FOR CLAIMS CLOSED DURING 2007

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)	758	$0	$9,896,757
$ 0 w/out DCCE (1)	504	$0	$0
$ 1 - 9,999	324	$1,442,155	$2,087,359
$ 10,000 - 49,999	186	$4,064,073	$4,627,644
$ 50,000 - 99,999	67	$4,697,065	$2,769,948
$ 100,000 - 249,999	51	$7,176,442	$2,297,681
$ 250,000 - 499,999	12	$3,254,620	$1,048,895
$ 500,000 - 749,999	3	$1,700,000	$311,886
$ 750,000 - 999,999	2	$1,865,000	$186,155
$ 1,000,000 and over	2	$2,000,000	$258,592
TOTAL	1,909	$26,199,355	$23,484,916

Notes: (1) The claims closed during 2007, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses (DCCE) Paid and "Claims without Defense & Cost Containment Expenses (DCCE) Paid."

DISTRIBUTION BY SIZE OF PAYMENT FOR CLAIMS CLOSED DURING 2007 (continued)

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)	54	$0	$3,885,488
$ 0 w/out DCCE (1)	61	$0	$0
$ 1 - 9,999	7	$20,085	$249,941
$ 10,000 - 49,999	10	$236,168	$384,810
$ 50,000 - 99,999	4	$277,526	$177,777
$ 100,000 - 249,999	6	$1,202,903	$1,148,343
$ 250,000 - 499,999	3	$1,145,000	$504,428
$ 500,000 - 749,999	1	$650,001	$97,170
$ 750,000 - 999,999	0	$0	$0
$ 1,000,000 and over	8	$14,242,200	$1,436,725
TOTAL	154	$17,773,883	$7,884,682

Notes: (1) The claims closed during 2007, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses Paid and "Claims without Defense & Cost Containment Expenses Paid."

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	$0	$325,895
$ 0 w/out DCCE (1)	17	$0	$0
$ 1 - 9,999	1	$2,500	$160
$ 10,000 - 49,999	9	$218,026	$159,522
$ 50,000 - 99,999	4	$312,281	$120,560
$ 100,000 - 249,999	1	$240,000	$117,891
$ 250,000 - 499,999	2	$590,000	$177,471
$ 500,000 - 749,999	0	$0	$0
$ 750,000 - 999,999	0	$0	$0
$ 1,000,000 and over	1	$1,000,000	$3,760
TOTAL	66	$2,362,807	$905,259

Notes: (1) The claims closed during 2007, without indemnity payment, should be broken down in two categories: Claims with Defense & Cost Containment Expenses (DCCE) Paid and "Claims without Defense & Cost Containment Expenses (DCCE) Paid."

2007 CLAIMS DATA: ALL HEALTH CARE PROVIDERS COMBINED

CLAIMS CLOSED WITH PAYMENT TO THE CLAIMANT DURING 2007						
Occurrence Year	Number of Claims [1]	Total Monetary Amount Paid [2]	Average Claim Payment [3]	DCCE Paid [4]	Loss & DCCE Paid [5]	Average Loss & DCCE Paid [6]
Pre 1999	34	$17,647,386	$519,041	$4,392,699	$22,040,085	$648,238
1999	13	$6,451,754	$496,289	$1,218,518	$7,670,272	$590,021
2000	38	$3,426,018	$90,158	$2,848,449	$6,274,467	$165,118
2001	53	$18,213,113	$343,644	$4,768,244	$22,981,357	$433,611
2002	77	$9,822,525	$127,565	$6,846,554	$16,669,079	$216,482
2003	175	$26,939,837	$153,942	$13,828,066	$40,767,903	$232,959
2004	390	$61,166,170	$156,836	$21,414,928	$82,581,098	$211,746
2005	437	$49,513,880	$113,304	$13,915,044	$63,428,924	$145,146
2006	232	$19,757,183	$85,160	$2,295,231	$22,052,413	$95,054
2007	96	$1,300,905	$13,551	$145,633	$1,446,538	$15,068
TOTAL	1,545	$214,238,770	$138,666	$71,673,367	$285,912,137	$185,056

CLAIMS CLOSED W/OUT PAYMENT to the CLAIMANT DURING 2007				ALL CLAIMS COMBINED
Occurrence Year	Number of Claims [7]	DCCE Paid [8]	Average DCCE Paid [9]	Average Claim Payment for ALL Claims Combined [10]
Pre 1999	313	$5,222,305	$16,685	$78,566
1999	60	$772,609	$12,877	$115,656
2000	118	$3,081,649	$26,116	$59,975
2001	191	$4,672,566	$24,464	$113,336
2002	304	$8,805,581	$28,966	$66,863
2003	614	$14,744,549	$24,014	$70,358
2004	1,354	$25,704,408	$18,984	$62,090
2005	2,308	$20,550,781	$8,904	$30,594
2006	1,795	$4,013,743	$2,236	$12,859
2007	435	$1,021,359	$2,348	$4,648
TOTAL	7,492	$88,589,549	$11,825	$41,441

Field Descriptions & Calculations for Claims Closed With or Without Payment to the Claimant During 2007 Data:

1 = Number of Claims with Payment to the Claimant
2 = Total Monetary Amount Paid
3 = Average Claim Payment (3=2/1)
4 = Defense & Cost Containment Expenses (DCCE) Paid
5 = Loss & Defense and Cost Containment Expenses Paid (5=2+4)
6 = Average Loss & Defense & Cost Containment Expenses Paid (6=5/1)
7 = Number of Claims without Payment to the Claimant
8 = Defense and Cost Containment Expenses Paid
9 = Average Defense & Cost Containment Expenses Paid (9=8/7)
10 = Average Claim Payment for ALL Claims Combined (10=[5+8]/[1+7])

2007 CLAIMS DATA: ALL HEALTH CARE PROVIDERS COMBINED (continued)

Occurrence Year	CLAIMS REPORTED for 1st TIME / REOPENED in 2007		CLAIMS OUTSTANDING as of 12/31/2007				MONETARY AMOUNT PAID ON CLAIMS DURING 2007	
	# Claims Reported for 1st Time During 2007	# Claims Re-Opened During 2007	# 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 (DCCE) Paid
Pre 1999	85	42	284	$10,684,806	$3,184,148	$4,636,998	$9,797,713	$3,643,790
1999	42	2	70	$2,713,371	$1,133,021	$4,540,461	$6,425,926	$1,341,441
2000	48	20	133	$12,691,643	$2,708,969	$18,192,122	$3,031,171	$5,574,097
2001	66	24	169	$14,697,124	$2,353,331	$13,945,670	$13,635,061	$5,874,759
2002	107	27	283	$21,235,430	$3,991,444	$32,645,567	$9,464,584	$8,980,810
2003	240	57	465	$34,493,781	$6,036,714	$34,542,652	$28,655,927	$18,984,428
2004	493	86	939	$75,985,112	$13,800,520	$111,343,408	$56,569,845	$41,478,766
2005	1,345	145	2,027	$102,926,382	$24,250,032	$155,757,889	$48,870,184	$51,550,744
2006	3,520	123	3,151	$94,770,072	$30,421,042	$212,901,508	$24,455,674	$20,483,606
2007	2,087	11	1,694	$23,842,906	$12,245,763	$200,065,086	$3,434,746	$3,363,987
TOTAL	8,033	537	9,215	$394,040,627	$100,124,983	$788,571,360	$204,340,831	$161,276,427

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

2007 CLAIMS DATA: BY TYPE OF HEALTH CARE PROVIDER

	CLAIMS CLOSED WITH PAYMENT TO THE CLAIMANT DURING 2007					
	Number of Claims [1]	Total Monetary Amount Paid [2]	Average Claim Payment [3]	DCCE Paid [4]	Loss & DCCE Paid [5]	Average Loss & DCCE Paid [6]
PHYSICIANS	840	$167,902,725	$199,884	$53,499,872	$221,402,597	$263,575
OTHER PROF	648	$26,199,355	$40,431	$13,594,936	$39,794,291	$61,411
HOSPITALS	39	$17,773,883	$455,741	$3,999,194	$21,773,077	$558,284
OTHER FAC	18	$2,362,807	$131,267	$579,365	$2,942,172	$163,454
TOTAL	1,545	$214,238,770	$138,666	$71,673,367	$285,912,137	$185,056

	CLAIMS CLOSED W/OUT PAYMENT to the CLAIMANT DURING 2007			ALL CLAIMS COMBINED
	Number of Claims [7]	DCCE Paid [8]	Average DCCE Paid [9]	Average Claim Payment for ALL Claims Combined [10]
PHYSICIANS	6,067	$74,488,188	$12,278	$42,839
OTHER PROF	1,261	$9,889,981	$7,843	$26,026
HOSPITALS	115	$3,885,486	$33,787	$166,614
OTHER FAC	49	$325,895	$6,651	$48,777
TOTAL	7,492	$88,589,549	$11,825	$41,441

Field Descriptions & Calculations for Claims Closed Data:

1 = Number of Claims with Payment to the Claimant
2 = Total Monetary Amount Paid
3 = Average Claim Payment (3=2/1)
4 = Defense & Cost Containment Expenses (DCCE) Paid
5 = Loss & Defense and Cost Containment Expenses Paid (5=2+4)
6 = Average Loss & Defense & Cost Containment Expenses Paid (6=5/1)
7 = Number of Claims without Payment to the Claimant
8 = Defense and Cost Containment Expenses Paid
9 = Average Defense & Cost Containment Expenses Paid (9=8/7)
10 = Average Claim Payment for ALL Claims Combined (10=[5+8]/[1+7])

2007 CLAIMS DATA: BY TYPE OF HEALTH CARE PROVIDER (continued)

	CLAIMS REPORTED for the FIRST TIME & CLAIMS REOPENED in 2007		CLAIMS OUTSTANDING as of 12/31/2007				MONETARY AMOUNT PAID ON CLAIMS DURING 2007	
	# Claims Reported for 1st Time During 2007	# Claims Re-Opened During 2007	# of Claims Outstanding	Dir Amount Reserved for Loss on Reported Claims (Case)	Dir 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	6,324	419	7,404	$341,052,590	$83,763,932	$652,248,579	$153,273,743	$128,573,113
OTHER PROF	1,525	97	1,579	$39,508,444	$10,732,393	$84,380,450	$25,954,995	$22,419,313
HOSPITALS	128	16	170	$11,599,412	$3,789,382	$35,686,512	$19,099,868	$7,136,090
OTHER FAC	56	5	62	$1,880,181	$1,839,276	$16,255,819	$6,012,225	$3,147,911
TOTAL	8,033	537	9,215	$394,040,627	$100,124,983	$788,571,360	$204,340,831	$161,276,427

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).