



A Risk Manager's Guide to Insurer Insolvencies

By Corinne Pavlis Carr

In response to the threat of additional insurer insolvencies, we have prepared the following “frequently asked questions” guide summarizing issues related to: (i) the financial regulation of insurance companies; (ii) the liquidation and proof of claim process; (iii) potential recovery by policyholders of the amount of “covered” claims from state guaranty associations; (iv) policyholder collateral; (v) dividend plans; (vi) disengagement transactions; and (vii) strategies for preparing for a liquidation.¹

I. FINANCIAL REGULATION OF INSURANCE COMPANIES

Who regulates the financial condition of insurers?

Because insurance is a state regulated industry, federal bankruptcy laws do not apply to insurers. Furthermore, a bankruptcy filing by a non-insurance holding company parent of insurance company subsidiaries does not in and of itself trigger insolvency proceedings against the insurance company subsidiaries. Rather, each state has a regulatory agency, in the form of the State Department of Insurance, which is responsible for monitoring the financial health of insurance companies authorized to do business in the state. When the “Commissioner,” “Superintendent” or “Director” of a Department of Insurance (the “Commissioner”) determines a company is in financial trouble, the Commissioner is empowered by state law to take appropriate steps to protect the policyholders and claimants of the company.

What action is the Commissioner authorized to take?

Depending upon the severity of the problem, the Commissioner can take a variety of corrective actions. These may include an *Order of Conservation*, an *Order of Rehabilitation* or an *Order of Liquidation*. The Kemper insurance companies, for example, are currently operating under a voluntary plan of run-off subject to the supervision of the Illinois Division of Insurance. The Reliance and Legion Insurance companies are currently in liquidation in Pennsylvania.

In New York, whenever the Superintendent finds from a financial statement or report on examination that an authorized insurer is unable to pay its outstanding lawful obligations as they mature in the regular course of business, such insurer shall be deemed “insolvent”. Upon such a finding, the Superintendent may seek (from the appropriate court) an *Order of Conservation*, an *Order of Rehabilitation* or an *Order of Liquidation*. New York insurance law also authorizes its Superintendent to determine that a domestic stock company is financially “impaired” if: (i) the admitted assets are less than the aggregate amount of its liabilities and outstanding capital stock; or (ii) the admitted assets of any such insurer are less than the aggregate amount of its liabilities and the amount of its minimum surplus to policyholders. The Superintendent is further authorized to determine the amount of the impairment and order the insurer to eliminate the impairment within a specified time period, not more than ninety days from the service of the order. The Superintendent may also order the insurer not to issue any new policies while the impairment exists. If the impairment equals or exceeds

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twenty-five percent of the insurer's outstanding capital stock or is such that the insurer does not satisfy minimum capital or surplus requirements, and if at the expiration of such designated period, such insurer has not satisfied the Superintendent that such impairment has been eliminated, the Superintendent may proceed against the insurer seeking an *Order of Conservation*, an *Order of Rehabilitation* or an *Order of Liquidation*.

What is a conservation?

A “conservation” occurs when the Commissioner, upon a court order, takes over the operations of a financially impaired insurance company. While there are many different reasons for a court with appropriate jurisdiction to issue such an *Order of Conservation*, the most common basis is a determination that: (i) the insurer is insolvent; and (ii) the Commissioner must operate the company in order to conserve assets for the benefit of policyholders, creditors, and other persons interested in the assets of the company. As the court-appointed Conservator, the Commissioner may continue as much, or as little, of the insurance business as the Commissioner deems appropriate. During conservation, one of the Commissioner's main duties is to conduct a thorough examination of the insurance company's books and records to determine whether the company can be rehabilitated so that it may return to operating as a “regular” insurance company (i.e., without the day-to-day management by the Commissioner). Normal payment of claims should continue during this process of conservation.

What is a rehabilitation?

In summary, an *Order of Rehabilitation* allows the company to continue its existence, but the Commissioner is appointed as the Rehabilitator and given the power to manage the company until the identified problems are corrected. If the problems cannot be corrected, the company may still be placed into liquidation by a subsequent *Order of Liquidation*. In New York, an *Order of Rehabilitation* directs the Superintendent, as Rehabilitator, to: (i) take possession of the property of the subject insurer; (ii) conduct the business operations of the subject insurer; and (iii) take such steps toward the removal of the causes and conditions which have made the rehabilitation proceeding necessary.

Although far less structured than a liquidation, a rehabilitation must include a rehabilitation plan that identifies (at least): (i) an explanation of the factors leading to the insurer's condition requiring rehabilitation and the procedures proposed to improve its condition, and (ii) a provision for posting collateral with the rehabilitator as security for any advance or funds, to the extent that the insurer's assets permit. In summary, the goal of a rehabilitation is to return the financially troubled insurer to strength and make it an active and profitable company, while at the same time protecting policyholders, creditors and the public. The Rehabilitator is given broad powers in both the court order and in statute, as well as a great deal of discretion to take actions to correct the conditions that caused the financial problems and prepare a plan to save the company. All powers of the Company's directors, officers and managers are suspended during the rehabilitation process and must be delegated by the Rehabilitator until the rehabilitation is terminated.

How is a rehabilitation terminated?

A rehabilitation will be terminated if the Commissioner, at any time, determines that further efforts to rehabilitate the financially impaired insurer would be futile. At such point, the Commissioner may apply to the appropriate court for an *Order of Liquidation*. Otherwise, a financially impaired insurer will be released from rehabilitation when the appropriate court of jurisdiction is satisfied that the insurer is ready to resume normal operations and the goals of the rehabilitation plan have been satisfied. Note that normal payment of claims should continue during this process of rehabilitation.

II. LIQUIDATION AND THE PROOF OF CLAIM PROCESS

What is a liquidation?

If the Commissioner does not believe a company's financial problems can be corrected and that continued operation of the company would be harmful to the company's policyholders and creditors, the Commissioner can seek an *Order of Liquidation* from the appropriate state court. Under an *Order of Liquidation*, the Commissioner is appointed as Liquidator of the company. The Liquidator will then appoint a Receiver to manage the actual liquidation process. Unlike a

conservation or rehabilitation proceeding, and as discussed below, normal payment of claims does not continue during this process of liquidation.

What is a proof of claim?

Following an *Order of Liquidation*, policyholders will receive, and must complete, a proof of claim for all known claims against the insolvent insurer. A proof of claim consists of a notarized written statement setting forth the details of the claim and includes documentation in support of the asserted claim. Policyholders must also submit a policy-specific proof of claim for each policy issued by the insolvent insurer for contingent (*i.e.*, “unknown” or “policyholder protection”) claims against the liquidator. The Liquidator will generally establish a claim filing deadline for filing proofs of claim against the insolvent insurer. If a proper proof of claim is not received by this deadline, the policyholder will not have a timely filed claim and the policyholder’s chances of participating in any distribution of estate assets or benefiting from guaranty association recovery for such claim(s) will be greatly diminished.

What is a claim filing deadline?

The claim filing deadline is the last day on which a proof of claim can be received by the Liquidator and accepted as timely filed for purposes of participating in any distribution of estate assets that may be made on allowed timely filed claims. Note that, if good cause exists, a proof of claim may be filed with the Liquidator after the claim filing deadline. Late filed proofs of claim participate in distributions of company assets, if at all, only after all allowed timely filed claims of general creditors have been paid in full.

When is a distribution made by the Liquidator?

If sufficient assets remain following the liquidation proceeding, the Liquidator will seek court approval to make a distribution of the insolvent insurer’s remaining assets. A distribution of assets may occur only after *all* of the insurer’s liabilities have been finalized. Furthermore, a distribution to *policyholders* may generally occur only *after* distributions have been made to satisfy other higher priority obligations such as administration costs, secured claims, and debts due employees. In summary, distributions of the remaining assets of the estate are made by priority level and are made on a *pro-rata* basis, meaning that each allowed creditor at the same priority level receives payment at the same percentage of its claim.

III. STATE GUARANTY ASSOCIATIONS

What are guaranty associations?

Guaranty associations are nonprofit organizations created by statute for the purpose of protecting policyholders from severe financial losses and preventing delays in claim payment due to the insolvency of an insurer. They do this by assuming responsibility for the payment of claims that would otherwise have been paid by the insurer, had it not become insolvent. Each state has one or more guaranty association(s), with each association handling certain types of insurance. Insurance companies are required to be members of the state guaranty association as a condition of being licensed to do business in the state.

How do guaranty associations obtain funds?

Guaranty associations obtain funds for their operations and payment of claims through assessments against the solvent insurance companies licensed to do business in the state and from the recovery of amounts paid on claims from the insolvent estate.

Do states have more than one guaranty association?

There are different types of guaranty associations. Some guaranty associations handle only claims related to life and health insurance. Some deal only with property and casualty insurance claims. Others address only workers’ compensation claims or other special lines of insurance. Although guaranty association laws are somewhat similar from state to state, significant differences do exist. For this reason, it is critical to determine which state guaranty association

has responsibility for a policyholder's particular claim as this will affect not only where a claim must be filed, but also whether that type of claim is "covered" and the maximum (if any) amount the guaranty association will pay for a "covered" claim.

When is guaranty association recovery triggered?

The provisions of the state guaranty association laws in most states will not be triggered unless and until a state court issues an *Order of Liquidation* with a finding of insolvency against the financially impaired insurer.

What happens to open claims?

Open claims will be transferred to the appropriate state guaranty associations by the Liquidator. The associations will evaluate the claims and determine which claims (if any) are "covered" claims which should be paid or settled with association funds. Claims are transferred to state guaranty associations in this manner *regardless of whether the claims are potentially "covered" claims*. For example, even claims within a policyholder's deductible or SIR will be transferred to the appropriate state guaranty association. Attempts to maintain control over the administration of claims (including claims for which the policyholder has no protection) are generally unsuccessful. Rather, state guaranty associations will contract with their own TPAs (or in some states, utilize internal claims staff) to administer open claims against the insolvent insurer. The policyholder will be invoiced for amounts paid to claimants that are not "covered" by the state guaranty association.

Who pays the claims handling expenses?

Under the National Association of Insurance Commissioners ("NAIC") Property and Liability Insurance Guaranty Association Model Act (the "NAIC Model Act"), the administrative expenses arising out of or related to the claims of the insolvent insurer and the overall liquidation process are generally charged against the estate of the insolvent insurer, thereby reducing the assets available for distribution to policy holders.

What requirements have to be met in order for a claim to be a "covered" claim?

In general, to be "covered" by a guaranty association, at a minimum, the claim must:

- Be unpaid - the claim must not have been previously paid by the insolvent insurer or another party;
- Exist before the insolvency or arise within 30 days after the *Order of Liquidation*;
- Be on a policy written by a company that was licensed to do business in the state, and in a line of business covered by the guaranty association. Policies sold by companies that are not members of the guaranty association are not covered;
- Be brought by a claimant or policyholder who is a resident of the state;
- Be filed with the guaranty association before the claim filing deadline (which may or may not be the same claim filing deadline set by the Liquidator); and
- Not be covered by other insurance. If there is other insurance from which the policyholder's claim may be paid, such insurance must first be exhausted before the guaranty association will pay any portion of the claim.

Are all workers' compensation claims "covered claims"?

While workers' compensation claims are generally covered claims. With the notable exception of California (where up to \$500,000 of excess workers' compensation claims are covered), claims arising under excess workers' compensation policies are generally not covered claims. Claim amounts within a policyholder's deductible or SIR are likewise excluded. Furthermore, as discussed below, the majority of guaranty associations exclude from their protection (or may require reimbursement for amount paid on behalf of) certain policyholders whose "net worth" exceeds a specified amount. Also, even in states in which a net worth or other exception does not currently exist (or is not enacted), administrative efforts continue to scale back or otherwise limit recovery available to large commercial insureds.

What are “net worth” exceptions?

Guaranty association laws in most states include provisions that exclude large commercial insureds and large third-party claimants from the class of “covered” claimants. More specifically, most states exclude from their protection certain insureds whose “net worth” exceeds a specified amount, usually \$25 or \$50 million. California and New York are notable examples of states that do *not* currently impose such a net worth restriction. Note that, the term “net worth” does *not* refer to the general financial status or profitability of the insured. Rather, generally speaking, an insured’s “net worth” is the remainder that is left after liabilities are deducted from assets. Furthermore, as a general rule, an insured’s net worth equals the *aggregate* of the net worth of the insured *and* all of the insured’s subsidiaries and affiliates. Of the guaranty association acts that contain a net worth provision, roughly half contain the NAIC Model Act provision which gives the association the right to seek reimbursement from an insured for third-party claims paid on behalf of that insured if the insured’s net worth exceeded \$50 million as of December 31st of the year preceding the date of the *Order of Liquidation*. It is noteworthy, that both the National Conference of Insurance Guaranty Funds (“NCIGF”) and the NAIC (in the form of the NAIC Model Act) have recommended that all states enact a \$25 million net worth exception for first-party claims (and a \$50 million net worth “reimbursement” provision) precluding recovery by large commercial insureds. Accordingly, it is certainly possible that additional states may enact a net worth provision in anticipation of additional insolvency proceedings.

What happens if a claim is not a “covered” claim?

The policyholder may file a claim for the unpaid portion of such claims with the Liquidator. As described herein, if sufficient assets remain following the liquidation proceeding, the Liquidator will seek court approval to make a distribution of the insolvent insurer’s remaining assets to policyholders for such unpaid claims.

Do policyholders need to file claims with both the Liquidator and the guaranty associations?

The claims filing process differs from state to state. In some states (and under the NAIC Model Act), the policyholder need only file a claim with the Liquidator and it is automatically considered to be filed with the guaranty association. In other states, policyholders must file the claim separately (and satisfy a separate deadline) with the Liquidator and the appropriate guaranty association. Accordingly, it is important that the policyholder carefully read all information it receives and follows the instructions provided. Even where notice to the guaranty association is not *required*, it is *recommended* that a “courtesy” notice is provided to the appropriate guaranty association.

Can a policyholder file a claim with more than one guaranty association?

The state guaranty association system is intended to assign a given claim to only one guaranty association. In rare instances, it may be possible that one association has primary responsibility for a claim, and another state guaranty association has secondary liability. In such cases it may be possible to file a claim with both associations, but in any event, the total amount paid cannot exceed the amount of coverage provided under the policy.

How long will it take for the guaranty associations to pay claims?

The amount of time it takes for a guaranty association to pay a claim can vary widely depending upon a number of factors, but claim payments usually begin as soon as possible following the *Order of Liquidation*. A period of 60 - 90 days is not uncommon. Note, however, to the extent possible, the Liquidator will likely pre-pay workers’ compensation benefits for a period of 4 - 8 weeks to allow adequate time for the guaranty associations to process claims files.

In general, what should policyholders expect when dealing with state guaranty associations?

There are significant procedural requirements and statutory limitations imposed upon recovery from state guaranty associations. Simply put, policyholders should expect that the entire claims process will become more complicated *and* more expensive. Certain policyholders should expect to receive significantly less for their claims than would have otherwise been available from the now insolvent insurer. Others should expect to “reimburse” guaranty association for claims amounts paid on their behalf. Recovery is further complicated where the policyholder operates in multiple

states. Accordingly, potential recovery from guaranty associations requires a critical analysis in all states in which the policyholder has open claims. For many policyholders, such recovery is not worth pursuing and the policyholder should consider entering into a disengagement transaction with the insurer.

What happens to existing litigation?

If the insolvent insurer is already defending the case, the guaranty association will take control of the case and will continue to defend or negotiate a settlement on the policyholder's behalf. The defense and amount of coverage provided will be on the same terms and conditions provided for in the insured's policy.

What special considerations exist for policyholders with captive reinsurance structures?

Policyholders whose insured programs are reinsured in captive facilities should consider the impact of a potential liquidation on such reinsurance. As an initial matter, insureds must determine whether their reinsurance structure includes a "cut-through" provision. A cut-through provision allows a party not in privity with the reinsurer (*i.e.*, the insured-employer) to have direct rights against the reinsurer under a reinsurance agreement. These cut-through rights generally are limited and are triggered only by specific events enumerated in the cut-through provision. Cut-through provisions may take the form of a specific clause or an endorsement attached to the reinsurance agreement. A cut-through provision often makes the underlying insured a beneficiary under the contract. Thus, a reinsurer usually will draft the cut-through provision so that when the reinsurer makes payments to a third-party, it will not be required to make payments to the reinsured or to a statutory receiver.

Absent a cut-through provision, reinsurance proceeds may become a general asset of the insolvent insurer's estate, thereby exposing the insured/captive reinsurer to potential "double" liability for its losses. Even where a cut-through provision is present, the liquidator may not find the provision to be valid. If a cut-through provision is not present, or not enforced, the standard insolvency clause included in virtually every reinsurance contract (providing that the reinsurer must pay the reinsurance proceeds to the liquidator based on the liability of the ceding company regardless of whether the liquidator has paid or ever will pay the claim) also puts the captive at risk of having to pay the liquidator for reinsured claims. Furthermore, as discussed below, collateral held by the insolvent insurer to secure reinsurance obligations under a captive reinsurance program may also become a general asset of the insolvent insurer's estate.

IV. POLICYHOLDER COLLATERAL

What happens to policyholder collateral securing deductible obligations during a liquidation?

The answer depends on the state of domicile of the insolvent insurer. Under Illinois law, for example, collateral used to secure obligations under a deductible agreement with an insolvent insurer is protected and must be used to fund or reimburse claims payments within the agreed deductible amount. In other words, such collateral will not be considered an asset of the estate, and as such, cannot be used to pay claims of other policyholders or creditors or to defray the Receiver's general administrative expenses. Pennsylvania insurance law provides similar protections. However, in most states (including New York), the treatment afforded policyholder collateral during a liquidation proceeding is currently unclear as state insurance laws are generally silent on this issue. Accordingly, there is some risk that, in the event of a liquidation proceeding of a New York domiciled insurer, certain policyholder collateral may become a general asset of the insolvent insurer's estate.

What happens to policyholder collateral securing "other" obligations during a liquidation?

Collateral held by an insolvent insurer to secure "other" obligations such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy may become an asset of the insolvent insurer's estate. Be aware of the *accounting treatment* your insurer may be giving collateral funds and special program features that may convert collateral or loss payments into *premium*, thereby jeopardizing the protection of such funds during a liquidation proceeding.

Is the Receiver obligated to review and/or adjust policyholder collateral during a liquidation?

Insurance laws in most states are silent on this issue. In Illinois, however, the Receiver must review and adjust the collateral annually, but is entitled to retain an amount sufficient to secure the “entire estimated ultimate obligation of the policyholder plus a reasonable safety factor” and may not return the collateral until all covered claims have been paid and Receiver is satisfied that no new claims can be presented. In Pennsylvania, the Receiver must “periodically adjust” the collateral being held, provided that “adequate” collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor. Note, however, the Receiver is not required to adjust the collateral more than once a year. The guaranty associations and the policyholder shall be informed of all such collateral reviews, including, but not limited to, the basis for any adjustment. Once all claims covered by the collateral have been paid and the Receiver is satisfied that no new claims can be presented, the Receiver will release any remaining collateral to the policyholder.

What administrative fees may be charged against policyholder collateral during a liquidation?

Insurance laws in most states are silent on this issue. However, in Illinois and Pennsylvania, the Receiver is entitled to deduct up to 3% of the amount actually collected by the Receiver from the amount of reimbursements owed to guaranty associations and/or policyholders or collateral to be returned to a policyholder for reasonable expenses incurred in fulfilling the Receiver’s responsibilities.

V. DIVIDEND PLANS

What does management need to understand about dividend plans and coinsurance obligations?

In general, dividend plans are designed so that an insured may receive a policyholder “dividend” if losses are less expensive than anticipated. Such dividends cannot by law be “guaranteed” as they are payable only upon declaration by the insurer’s board of directors and in compliance with applicable insurance law and regulation. Dividends are generally determined 6 months after policy expiration (and annually thereafter) on a “sliding scale” (tied to the insured’s underwriting loss results) basis that is limited by minimum and maximum premium obligations. More specifically, dividend plans generally start with the expectation of a particular loss ratio. If the insured develops a lower than expected loss ratio, the insured is entitled to a potential dividend (if declared). Conversely, if the insured develops a higher than expected loss ratio, the insured loses the opportunity to receive a dividend. Furthermore, dividend plans generally include a “recapture” or “adjustment” provision which requires the insured to “pay back” prior year dividends if, at subsequent valuations, claims deteriorate. This recapture process continues until all claims are settled or mutually agreed upon as to value. Many dividend plans include a “coinsurance” provision under which the insured becomes a “coinsurer” of its losses that exceed the amount of losses that produces a \$0 dividend.

What happens to dividend payments during an insolvency?

An insolvent insurer will not be permitted to continue to “declare” or “approve” recommended dividends on expired policies. As a result, many policyholders may face large (and unanticipated) premium adjustment invoices and dividend recapture invoices.

VI. DISENGAGEMENT TRANSACTIONS

What is a disengagement transaction?

Although subject to variation, the buy-back and novation transaction is, conceptually at least, fairly straight forward. In summary, in exchange for the return of a percentage of the insolvent insurer’s reserves, the insured agrees to “buy back” the non-statutory (i.e., insurance the insured is not legally required to secure/maintain) general liability and automobile liability coverages issued by the insolvent insurer. These policies are essentially extinguished, thereby leaving the insured self-insured for future losses. Because workers’ compensation insurance is a statutory (i.e., mandatory) coverage, the insured, insolvent insurer and an assuming carrier enter into a novation transaction whereby the assuming carrier assumes legal responsibility, on a go-forward basis, for the workers’ compensation policies issued to the insured.

In summary, the assuming carrier “steps into the insolvent insurer’s shoes,” who is then released from all future liabilities. Potential variations of this “basic” structure include a transaction that is structured to include the insured’s captive or an optional “LPT” contractual indemnity policy insuring the insured’s deductible/SIR obligations.

What indemnification obligations does the insured typically assume?

Disengagement transactions typically include a contemporaneous agreement between the insured and the assuming carrier whereby the insured agrees to reimburse or “indemnify” the assuming carrier for all losses. In other words, much like a fronting arrangement between an insurer and a reinsuring captive, the insured essentially “borrows” the assuming carrier’s paper for the purpose of satisfying workers’ compensation laws, but the insured is essentially self-insured for all future liabilities, including liabilities previously within the insolvent insurer’s layer.

If a policyholder enters into a disengagement transaction with an insolvent insurer, can it be set aside as a “preference” during liquidation?

The answer depends on the state of domicile of the insolvent insurer. Insurance laws in most states are silent on this issue. Illinois insurance law, for example, protects the types of disengagement transactions that insolvent insurers execute with policyholders during run-off from later being set aside. Specifically, where the Director of the Illinois Division of Insurance approves a pre-receivership transfer (including a disengagement transaction such as a novation and/or buy-back) by the insurer in writing, such a transfer *cannot* later be found to constitute a prohibited or avoidable transfer based solely upon a deviation from the statutory receivership payment priorities. Such a deal can, however, still be challenged for other reasons, such as fraud. New York insurance law offers similar, but more limited, protection of certain disengagement transactions.

VII. PREPARING FOR A LIQUIDATION

What steps should a policyholder take to prepare for a potential liquidation?

- **Know your exposure**
 - Prepare a chart identifying the coverages, limits, deductibles, SIRs, premium deferral plans, collateral obligations and other key financial terms of programs issued by each insurer.
 - Ensure you have proper documentation (i.e., insurance proposals, forms, endorsements, invoices and all related agreements) for *all* years.
 - Be aware of related M&A activity and any problems you may have “inherited” through M&A activity.
 - Identify excessive exposures to insolvencies based on the length of time and scope of coverage with a single insurer.

- **Understand your Collateral Position**
 - Prepare a summary of all outstanding collateral posted with insurers to secure all policyholder obligations.
 - Allocate “categories” of collateral by type of obligation secured (i.e., deductibles, dividend plans, retro and deferral premiums, reinsurance arrangements, etc.). Confirm these allocations under the terms of your insurance agreements *and* with your insurer.
 - Be aware of the *accounting treatment* your insurer may be giving these funds and special program features that may convert loss payments into premium.

- **Protect your Collateral**
 - Analyze whether you are over/under collateralized.
 - Approach insurers regarding means by which this security may be reduced or eliminated.
 - Demand the timely review/reduction of required policyholder collateral and escrowed funds.
 - Review the form of collateral and consider alternative forms such as a segregated trust in place of cash accounts.

- **Close Claims**

- Forecast the amount of claims payments the insurer will make on the policyholder's behalf across the next 6, 12 and 18 months.
- Expedite claims settlement by engaging a third-party to implement an expedited claims settlement initiative.

- **Plan and Prepare for the Liquidation**

- Engage experienced counsel at the onset.
- Prepare a written plan detailing your response to a liquidation of the financially impaired insurer as soon as possible.
- Understand the liquidation process and related deadlines.
- Analyze potential recovery from applicable state guaranty associations and establish communication with these funds as soon as possible.
- Be prepared to file proofs of claims with the Receiver and state guaranty associations.
- Understand the impact of a liquidation on any captive reinsurance structures.
- Understand the accounting implications of the liquidation and resulting liabilities.
- Identify internal personnel responsible for satisfying requirements and tracking the liquidation process.

- **Consider a “Disengagement Transaction”**

- Partner with your broker and counsel to evaluate the options, costs and benefits of a disengagement transaction (*i.e.*, novation, buy-back or reinsurance cut-through) with the insurer.

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EXHIBIT I

DISENGAGEMENT TRANSACTIONS - POLICYHOLDER ALTERNATIVES

OPTION/STRATEGY	PROCESS	VALUE/PROS	COSTS/CONS
<p>NOVATION & BUY-BACK TRANSACTION</p> <p>(DISENGAGEMENT TRANSACTION)</p>	<ul style="list-style-type: none"> • Execute Letter of Intent and confidentiality agreement with insolvent insurer and assuming carrier • Evaluate value of claims for purposes of collateral requirement • Negotiate final terms • Secure DOI approval (may eliminate “preference” risk) • Execute transaction, including posting of new collateral as required by assuming carrier 	<ul style="list-style-type: none"> • Removes policyholder from liquidation proceedings • Receive 25% of reserves from insolvent insurer • Return of policyholder collateral • Control claims handling process and expenses • Final resolution of adjustments to premium and/or dividends • Elimination of credit risk 	<ul style="list-style-type: none"> • Expense of new collateral obligation • Legal/administrative expenses of transaction • Loss of potential guaranty association recovery and distribution from the Receiver • Loss of value of claims payment insolvent insurer would have made prior to liquidation
<p>NO TRANSACTION</p>	<ul style="list-style-type: none"> • Continue effort to expedite closing of claims • Complete Proof of Claim process • Pursue any available guaranty association recovery • Pursue distribution from Receiver following liquidation proceedings 	<ul style="list-style-type: none"> • Potential guaranty association recovery • Potential distribution from Receiver • No transaction expenses 	<ul style="list-style-type: none"> • Lengthy liquidation proceedings (at least 10 years) • Difficulties securing review/reduction of policyholder collateral and 3% fee • Guaranty association recovery limited due to net worth exceptions • Lengthy Proof of Claim process • Limited distribution from the Receiver • Loss of control over claims handling process • Ongoing adjustments to premium and/or dividends • Ongoing credit risk



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Ms. Carr is a partner in Sonnenschein's Insurance Regulatory Practice and the Co-Chair of the firm's Risk Management Committee. Her practice focuses on insurance regulatory, transactional and risk management law.

Ms. Carr represents foreign and domestic insurers and reinsurers, as well as agents, brokers, employee leasing and temporary staffing companies and other insurance licensees and service providers in significant business and regulatory matters. These include negotiations with state regulatory entities on matters of compliance and market conduct. She also regularly advises corporate risk managers regarding significant insurance and reinsurance matters, including matters of insurer insolvency, self-insurance, direct procurement, premium allocation/taxation, claims-handling, domestic and off-shore captive facilities and other strategic insurance matters.

Education

University of Notre Dame
Law School, J.D., 1994

St. Mary's College, Notre
Dame, B.A., Political
Science and History, 1991

Practice Area(s)

Insurance

Insurance Regulatory

-Compliance

-Licensing

- Excess & Surplus Lines

-Risk Retention and
Purchasing Groups

-Run-off Operations

-Product Development

Insurance Transactional Law

-Mergers, Acquisitions and
Divestitures

Risk Management

Surety

Reinsurance

Agent and Broker

Prior Law Firm Experience

DLA Piper

Duane Morris LLP

Prior Insurance Industry Experience

The Allstate Corporation

Fireman's Fund Insurance Company

Representative Experience

Representation of Insurance Industry Clients

Represented domestic and foreign insurers, reinsurers and other licensees before various state regulatory bodies on compliance issues related to licensing, certificates of authority, the sale of securities and variable annuity products, market conduct examinations, responses to significant consumer or department complaints, rate and form filing approvals, withdrawal, out-sourcing, disclosure requirements, record retention, insolvency, limited lines issues and what constitutes the transaction of insurance and/or reinsurance.

Represented the Discontinued Operations unit of a large property and casualty insurance company in the design, negotiation and implementation of run-off strategies relating to workers' compensation, private passenger automobile, professional liability, automobile warranty and other books of run-off business.

Represented a large property and casualty insurance company with

Admitted to Bar

Illinois

respect to compliance matters related to the regulation of financial guaranty insurance and “excess deposit” surety bond products.

Represented a large property and casualty insurance company with respect to the strategic planning, implementation and negotiation of a withdrawal from commercial surety lines writings, including advice specific to bankruptcy, receivership, gas and oil, guardianship, probate, conservator and reclamation bond obligations.

Represented domestic and foreign reinsurers in matters related to reinsurance obligations, treaty analysis, security fund agreements, statutory credit for reinsurance, mandatory participation in (and assessments by) state insurance funds and advised regarding pending legislation, including TRIA extension.

Represented a large national insurance brokerage firm with respect to an entity-wide compliance review and the drafting of a comprehensive compliance manual.

Represented a large surplus lines insurance company in the planning, development and roll-out of homeowners, multiple property and other liability programs.

Represented a large foreign insurer with respect to its assessment of whether to enter the U.S. life and health market.

Represented a large national insurance broker in responding to regulatory inquiries concerning contingent commission issues.

Represented insurance companies in an operational merger with affiliated companies within an international insurance holding company, including advisement on assumption of contracts and liabilities, product assimilation, regulatory matters, and employee retention and reduction.

Provided strategic research and analysis on regulatory and operational issues, including licensing, compensation, presence and citizenship issues, to a large consulting client developing a new model for global insurance business process outsourcing.

Represented a reinsurer in the negotiation of a multimillion-dollar commutation of reinsurance contracts covering an auto service contract business as well as the commutation of reinsurance covering other personal lines products and related dispute resolution.

Managed all aspects of formation, maintenance and administration for purchasing groups on behalf of a domestic insurer.

Authored a 50-state guide book, and provided representation to insurance companies before multiple state regulatory bodies, relating to the compliance issues arising from withdrawal from the market place.

Drafted a 50-state guide book analyzing TPA, MGA, adjuster and producer

licensing requirements and related issues such as record retention, producer compensation and disclosure requirements.

Representation of Corporate & Risk Management Clients

Represented corporate risk managers in negotiating commutations, novations, loss portfolio transfers, policy buy-backs and other disengagement transactions with financially troubled insurers, excess insurers and reinsurers.

Advised corporate risk managers in the development of domestic and off-shore captive facilities (including single parent, association, group, agency and rent-a-captive facilities) and the negotiation of related reinsurance agreements.

Represented employers, captive insurers and reinsurers regarding complex worker's compensation reinsurance and fronting arrangement, including advice regarding policyholder collateral, cut-through access to reinsurance proceeds, claim handling, commutation, guaranty fund protection, set-off and proof of claim issues.

Advised corporate risk managers regarding significant workers' compensation matters related to mergers and acquisition activity, premium plans (such as deferral, retrospective rating, policyholder dividends, excess loss premium, incurred loss and paid loss plans), as well as issues related to insurer insolvency such as the reduction/return of policyholder collateral, proof of claim submission and guaranty fund protection.

Represented an international shipping company with respect to matters related to shipper's insurance, non-insurance declared value products, captive reinsurance structures, the Carmack Amendment, pricing, licensing and general compliance.

Represented a large national software vendor in the strategic development, negotiation and implementation of a computerized database providing valuations for total loss and partial loss vehicle claims.

Represented employee leasing and temporary staffing companies on matters related to workers' compensation insurance, insurer insolvency, exclusive remedy protection and captives, including regulatory litigation involving unprecedented attempts by a state guaranty fund to avoid liability under "other insurance" theories.

Represented a wireless communications service provider in the strategic development, negotiation and implementation of a wireless equipment service program.

Represented an international office equipment leasing company in the strategic development, negotiation and implementation of a warranty service program.

Provided strategic advice with respect to vehicle dealerships defending

class action litigation involving theories of unauthorized and unfair insurance practices related to vehicle warranty programs.

Represented a savings bank with respect to insurance regulatory matters relating to referral fees and the sale of insurance products by its affiliates.

Represented a large real estate brokerage firm with respect to its creation of a wholly-owned insurance subsidiary for purposes of cross-selling flood, title and homeowners insurance products to its clients.

Publications

Author, *A Risk Manager's Guide to Insurer Insolvencies*, (2008)

Author, *A Guide to Surviving the Kemper Insolvency*, (2007)

Co-Author, "Annotation to Surplus Lines Statutes" *ABA Tort and Insurance Practice Section*, (2005)

Author, *50 State Guidebook on Withdrawal of an Insurance Product*, (2004)

Organizations

- Associate Member, Risk and Insurance Management Society (RIMS), 2007-present
- Member, Insurance Regulatory Examiner's Society (IRES), 2007 - present
- Member, American Bar Association, 1994 - present
- Vice Chair, Excess & Surplus Lines and Reinsurance Committee of the American Bar Association Tort and Insurance Practice Section, 2006 - 2007
- Member, Illinois State Bar Association, 1994 - present
- Member, Chicago Bar Association, 1994 - present
- Associate Member, NAPEO (Present)

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