IAIR TECHNICAL DEVELOPMENT SERIES VI

Session 6: How Solvent Carriers Deal with Insolvent Estates

October 12, 2018
11:15am – 12:25pm

Moderator: Benjamin H. Nissim – Associate, Day Pitney LLP

Panelist: William E. Lohnes – Assistant General Counsel – Reinsurance Law; The Harford Financial Services Group, Inc.

Panelist: David B. Heintz – Senior Counsel – Special Liability Group Claim Legal; The Travelers Insurance Companies

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

ORDER ADOPTING REPORT OF EXAMINATION

I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having fully considered and reviewed the Examination Report (the "Report") of ACE Life Insurance Company (the "Company") as of December 31, 2016, do hereby adopt the findings and recommendations contained therein based on the following findings and conclusions.

TO WIT:

1. I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, and as such is charged with the duty of administering and enforcing the provisions of Title 38a of the Connecticut General Statutes ("C.G.S.").

2. The Company is a domestic insurer authorized to transact the business of insurance in the State of Connecticut.

3. On March 5, 2018, the verified Report of the Company was filed with the Connecticut Insurance Department (the "Department").

4. In accordance with C.G.S. §38a-14(e)(3), the Company was afforded a period of thirty (30) days within which to submit to the Department a written submission or rebuttal with respect to any matters contained in the Report.

5. On March 30, 2018, the Company filed a written submission indicating that they were in agreement with all of the recommendations contained in the Report. A copy of the Report is attached hereto and incorporated herein as Exhibit A.

NOW, THEREFORE, it is ordered as follows:

1. That the Report of the Company hereby is adopted as filed with the Department.

2. That the Company shall comply with the recommendations set forth in the Report, and that failure by the Company to so comply shall result in sanctions or administrative action as provided by Title 38a of the C.G.S.

3. Section 38a-14(e)(4)(A) of the CGS requires that:

   "The secretary of the Board of Directors or similar governing body of the entity shall provide a copy of the report or summary to each director and shall certify to the Commissioner, in writing, that a copy of the report or summary has been provided to each director. "

   Please address the certification to the Commissioner, but send said certification to the care/attention of Mark Murphy, Supervising Examiner, of the Financial Regulation Division.

4. Section 38a-14(e)(4)(B) of the CGS requires that:

   "Not later than one hundred twenty days after receiving the report or summary.the chief executive officer or the chief financial officer of the entity examined shall present the report of summary to the entity's Board of Directors or similar governing body at a regular or special meeting. "

   This will be verified by the Insurance Department either through analysis or examination follow-up.

Dated at Hartford, Connecticut, this 4th day of April, 2018.

Katharine L. Wade
Insurance Commissioner

Exhibit A

EXAMINATION REPORT

OF

ACE LIFE INSURANCE COMPANY
(NAIC # 60348)

AS OF

DECEMBER 31, 2016

BY THE

CONNECTICUT INSURANCE DEPARTMENT

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February 14, 2018

The Honorable Katharine L. Wade
Insurance Commissioner
State of Connecticut Insurance Department
153 Market Street
Hartford, CT 06103

Dear Commissioner:

In compliance with your instructions and pursuant to the requirements of Section 38a-14 of the Connecticut General Statutes (CGS), the undersigned has conducted a financial examination of the condition and affairs of the

ACE LIFE INSURANCE COMPANY

(hereinafter referred to as the Company or ACE Life), a capital stock corporation incorporated under the laws of the State of Connecticut and having its statutory home office located at Two Stamford Plaza, 281 Tresser Boulevard, Stamford, CT. The report of such examination is submitted herewith.

SCOPE OF EXAMINATION

The previous examination of ACE Life was conducted by the Financial Regulation Division of the Connecticut Insurance Department (Department) as of December 31, 2011. The current examination, which covers the subsequent five year period, through December 31, 2016, was conducted at the main administrative office of the Company.

As a part of the examination planning procedures, the Department reviewed the following documentation submitted by the Company:

- Annual Statements filed with the Department from 2012 through 2016;
- Management's Discussion and Analysis from 2012 through 2016;
- Statements of Actuarial Opinion for 2015 and 2016;
- minutes of the Board of Directors (Board) and Committees of the Board, custodial agreements, and other documents related to significant transactions that require prior Department approval; and
- the statutory-basis audit reports prepared by PricewaterhouseCoopers, LLP (PwC), the Company's independent certified public accountants, from 2012 through 2016.

A comprehensive review was made of the pre-examination memorandum and other documents provided by or submitted to the Financial Analysis Unit of the Department, as well as reports obtained from the National Association of Insurance Commissioners (NAIC) database.

The examination was conducted on a full scope, comprehensive basis in accordance with the procedures outlined in the NAIC Financial Condition Examiners Handbook (the Handbook). The Handbook requires that we plan and perform the examination to evaluate the financial condition and identify prospective risks of the Company by obtaining information about the Company, including corporate governance, identifying inherent risks within the Company and evaluating system controls and procedures used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management compliance with the NAIC Accounting Practices & Procedures Manual (Manual) and the NAIC Annual Statement Instructions.

Work papers prepared by PwC as of December 31, 2016, in connection with their statutory annual audit were reviewed and relied upon to the extent deemed appropriate.

The examination considered prospective risks, those risks that existed at the balance sheet date that will impact future operations or risks associated with future business plans of the Company. Examination procedures were performed as deemed appropriate to evidence actions that the Company had taken to mitigate these risks. These risks were communicated to individuals in the Department responsible for continued monitoring.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process.

Comments in this report are generally limited to exceptions noted or to items considered to be of

a material nature.

Failure of items in this report to add to totals or for totals to agree with captioned amounts is due to rounding.

HISTORY

The Company was incorporated in New Jersey on May 20, 1965, as American Eagle Life Insurance Company and commenced business on August 31, 1965.

Effective December 31, 1974, the Company was acquired by United States Fire Insurance Company, a subsidiary of Crum and Forster Holding, Inc. The Company's name was changed to Crum and Forster Life Insurance Company on June 26, 1978.

On December 12, 1979, the Company was acquired by Charter Security Life Insurance Company, a Louisiana company. The Company's name was changed to Charter Security Life Insurance Company on March 11, 1980.

Metropolitan Life Insurance Company acquired the Company on January 10, 1985, and changed its name to Metlife Security Insurance Company on June 20, 1985.

Swiss Reinsurance Company acquired the Company on January 31, 1991, and changed its name to Alpine Life Insurance Company on June 21, 1991.

The Company was acquired by Hartford Life and Accident Insurance Company (HLAC) on December 21, 1994.

On November 23, 1998, the Company re-domesticated from New Jersey to Connecticut and changed its name to Hart Life Insurance Company (Hart Life), effective December 22, 1999.

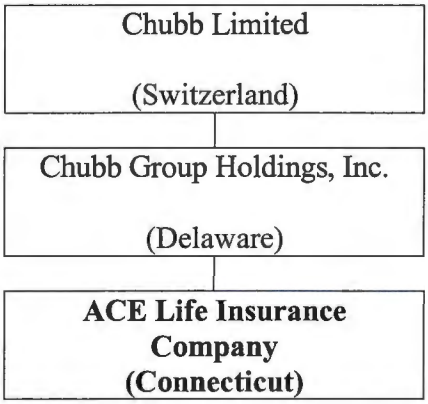
On April 28, 2006, HLAC sold its 100% interest in Hart Life to ACE Group Holdings, Inc. (ACE Group). Hart Life was renamed ACE Life Insurance Company, effective May 10, 2006, upon an execution amending and restating its articles of incorporation.

Effective January 15, 2010, ACE Group decided to discontinue assuming new traditional life reinsurance business underwritten through ACE Life, as it was not strategically core to the overall corporate business plan.

On January 14, 2016, ACE Limited completed the acquisition of the Chubb Corporation. Subsequent to the acquisition, ACE Limited changed its name to Chubb Limited.

ORGANIZATIONAL CHART

A partial organizational chart of the insurance holding company system at the end of the examination period is as follows:



ACE Life is 100% owned by Chubb Group Holdings Inc. (Chubb Group) and is part of a holding company structure in which the ultimate parent company, Chubb Limited is publicly traded.

MANAGEMENT AND CONTROL

The amended and restated bylaws of the Company require an annual meeting of stockholders to be held for the election of directors at such date, time and place, either within or without the State of Connecticut, as may be designated by resolution of the Board.

Special meetings of stockholders may be called at any time by the chairman of the Board (Chairman), vice chairman of the Board (vice chairman), if any, the president, a vice president, or the Board.

At each meeting of stockholders, except where otherwise provided by law, or the certificate of incorporation, or the bylaws, the holders of a majority of the outstanding shares of each class of stock entitled to vote at the meeting, present in person or by proxy, shall constitute a quorum.

The Board shall consist of one or more members, the number thereof to be determined from time to time by resolution of the Board. Directors need not be stockholders. At the first annual meeting of stockholders and at each annual meeting thereafter, the stockholders shall elect directors, each to hold office until the next succeeding annual meeting or until his successor is elected and qualified or until his earlier resignation or removal. Regular meetings of the Board may be held at such places within or without the State of Connecticut and at such times as the Board may from time to time determine.

Special meetings of the Board may be held at any time or place within or without the State of Connecticut, whenever called by the chairman, if any, by the vice chair, if any, by the president, by a vice president, or by two or more members of the Board.

Directors serving the Company at December 31, 2016, were as follows:

Name	Title and Principal Business Affiliation
Michael R. Hoag	President and Chairman
Michael H. Buthe	Chief Investment Officer
Annette M. Donselaar	Secretary

The Board may, by resolution passed by a majority of the whole Board, designate one or more committees, each committee to consist of two or more of the directors of the Company. As of December 31, 2016, the Company did not have any committees. ACE Life's ultimate parent company, Chubb Limited, has an Audit Committee consisting of five (5) members of the Board of Directors, each of whom is independent of Chubb Limited and its management.

Directors serving the Chubb Limited Audit Committee at December 31, 2016, were as follows:

Michael G. Atieh
James I. Cash, Jr.
Kimberly A. Ross
Theodore E. Shasta
David H. Sidwel

Officers serving the Company at December 31, 2016, were as follows:

Name	Title
Michael R. Hoag	President and Chairman
Joseph C. Forrest	Treasurer
Annette M. Donselaar	Secretary and General Counsel
Alex E. Dobzanski	Chief Financial Officer

RELATED PARTY AGREEMENTS

The Company is a party to several related party transaction agreements. The material agreements are as follows:

Administrative Services Agreement
The Company has an Administrative Services Agreement with an affiliate, ACE American Insurance Company (ACE American), to provide facilities, property, equipment, accounting, tax and auditing, payroll, reinsurance recovery and other similar administrative and operational functions to the Company on a cost expense allocation basis.

Investment Advisory Services Agreement
The Company has an Investment Advisory Services Agreement with ACE Asset Management Services, Inc. (AAMS) regarding the management of the Company's assets by AAMS. The Company is charged a management fee based on the average market value of the invested asset portfolio. The investment objectives and a statement of the restrictions on the investment of the assets of the Company are included in the agreement.

Tax Allocation Agreement:
The Company entered into a Tax Allocation Agreement with Chubb Group, and the subsidiaries of its principal shareholder group, to file a consolidated federal income tax return. The tax sharing allocation agreement provides that any subsidiary having taxable income will pay a tax liability equivalent to what that subsidiary would have paid if it had filed a separate federal income tax return for the year. A subsidiary that would result in a tax loss would receive the benefit resulting from such loss.

INSURANCE COVERAGE

The Company is insured with affiliates on a financial institution bond that was issued by the National Union Fire Insurance Company of Pittsburgh, PA. The named insured is Chubb Group, and the policy includes a single loss limit of $10 million and a single loss deductible of $10 million.

The Company is also insured with affiliates on a financial institution bond issued through Lloyd's of London and coinsured by AIG Europe Limited, London and Beazley Insurance Company (Beazley). The named insured is Chubb Limited (Switzerland) and the policy provides the combined aggregate limit of liability for all loss amounts covered under both AIG bonds and the Beazley bond of $15 million and $10 million respectively, for a combined limit of liability of $25 million.

The aggregate limit of liability provides coverage which exceeds the suggested minimum limits of insurance pursuant to the Handbook.

TERRITORY AND PLAN OF OPERATION

The Company has been in run-off since January 15, 2010, but is licensed to write life and accident and health insurance on a reinsured basis in all states except New York and the District of Columbia.

REINSURANCE

Assumed Reinsurance
The Company has amended or terminated existing contracts with its reinsurers or cedants, but has not entered into any new contracts subsequent to run-off of business in 2010. Although the Company continues to collect assumed reinsurance associated with credit life and A&H coverage, nearly the entire block of assumed business consists of yearly renewable term (YRT) reinsurance on ordinary life. The majority of that business is assumed from Lincoln National Life Insurance Company and Primerica Life Insurance Company, non-affiliated, U.S insurance companies.

Retroceded Reinsurance
Effective October 1, 2008, the Company amended the Automatic Coinsurance Retrocession Agreement with ACE Tempest Life Reinsurance, Ltd. (ATLRBDA), an affiliated, unauthorized reinsurer. In 2016, ATLRBDA's name was changed to Chubb Tempest Life Reinsurance Ltd.

(Chubb Tempest). The Company is the beneficiary to a letter of credit maintained by Chubb Tempest. The Company retains 20% of each individual or joint life risk up to a maximum of $200,000 per life and cedes to Chubb Tempest 80% on a coinsurance basis, up to a maximum of $800,000 per life, varying by issue age and substandard rating. The remaining business in excess of amounts covered by Chubb Tempest is retroceded to a pool of non-affiliated retrocessionaires.

INFORMATION TECHNOLOGY CONTROLS

The Department performed a risk-based assessment and review of Information Technology (IT) General Controls (ITGC's) in accordance with NAIC requirements as outlined in the Handbook. The guidance and direction used to perform the review of the ITGC's was derived from Exhibit C Part One – Information Technology Planning Questionnaire (ITPQ) and Exhibit C - Part Two – Information Technology Work Program (collectively Exhibit C). The Company's responses to the ITPQ were evaluated and it was determined that the primary IT functions were outsourced to the vendor LOGICQ3. As a result of this outsourcing and the substantive approach being taken on the examination, the IT review was limited to a review of the SSAE16 report for LOGICQ3 and a review of the ITPQ responses and related attachments.

Based upon the risk-based assessment and review no significant finding were identified. However, due to the limited testing performed a determination of the overall effectiveness of the IT general controls environment was not made.

ACCOUNTS AND RECORDS

The Company uses the PeopleSoft general ledger system to process and maintain financial accounting records. The Company uses Booke and The Complete Package software program to assist in the preparation of its annual statements. Adjusting entries are posted on a monthly basis. General ledger account balances were reconciled and traced to appropriate asset, liability, and income statement lines on the Annual Statement for 2016.

FINANCIAL STATEMENTS

The following statements represent the Company's financial position, as filed by the Company, as of December 31, 2016. No adjustments were made to surplus as a result of the examination.

ASSETS

Account Description	Assets	Non-admitted Assets	Net Admitted Assets
Bonds	$26,482,096		$26,482,096
Cash, cash equivalents and short-term investments	14,555,667		14,555,667
Receivables for securities	1,444		1,444
Investment income due and accrued	117,660		117,660
Premiums and considerations:			
Uncollected premiums and agents' balances in the course of collection	(5,683,829)		(5,683,829)
Reinsurance:			
Amounts recoverable from reinsurers	15,711,841		15,711,841
Other amounts receivable under reinsurance contracts	521,942		521,942
Net deferred tax asset	13,703,175	$13,703,175	
Aggregate write-ins for other than invested assets	246,586	246,586	
Total assets excluding Separate Accounts, Segregated accounts and protected cell accounts	65,656,582	13,949,761	51,706,821
Total	$65,656,582	$13,949,761	$51,706,821

LIABILITIES, SURPLUS AND OTHER FUNDS

Account Description	Total
Aggregate reserves for life contracts	$23,258,534
Contract claims:	
Life	5,393,975
Accident and health	31
Interest maintenance reserve	60,206
Commissions and expense allowances payable on reinsurance assumed	40,302
General expenses due or accrued	213,665
Taxes, licenses and fees due or accrued	147,230
Miscellaneous liabilities:	
Asset valuation reserve	24,822
Payable to parent, subsidiaries and affiliates	13,895,523
Aggregate write-ins for liabilities	2,587
Total liabilities	43,036,875
Common capital stock	2,500,000
Gross paid in and contributed surplus	39,930,275
Unassigned funds (surplus)	(33,760,329)
Total capital and surplus	8,669,946
Total liabilities, capital and surplus	$51,706,821

ACE LIFE INSURANCE COMPANY

SUMMARY OF OPERATIONS

Premiums and annuity considerations for life and accident and health contracts	$6,890,673
Net investment income	474,958
Amortization of Interest Maintenance Reserve (IMR)	17,148
Commissions and expense allowances on reinsurance ceded	1,761,738
Totals	9,144,517
Death benefits	7,321,220
Disability benefits and benefits under accident and health contracts	(3)
Increase in aggregate reserves for life and accident and health contracts	1,714,307
Totals	9,035,524
Commissions and expense allowances on reinsurance assumed	512,107
General insurance expenses	1,151,844
Insurance taxes, licenses and fees, excluding federal income taxes	416,294
Totals	11,115,789
Net gain from operations before dividends to policyholders and federal income taxes	(1,971,252)
Net gain from operations after dividends to policyholders and before federal income taxes	(1,971,252)
Federal and foreign income taxes incurred	0
Net gain from operations after dividends to policyholders and federal income taxes and before realized capital gains or (losses)	(1,971,252)
Net realized capital gains or (losses) less capital gains tax	0
Net income	$(1,971,252)

CAPITAL AND SURPLUS ACCOUNT

Capital and surplus, December 31, prior year	$8,583,067
Net income	(1,971,252)
Change in net deferred income tax	663,142
Change in nonadmitted assets	(628,946)
Change in liability for reinsurance in unauthorized and certified companies	19,613
Change in asset valuation reserve	6,205
Surplus adjustments: Paid in	2,000,000
Aggregate write-ins for gains and losses in surplus	(1,883)
Net change in capital and surplus for the year	86,879
Capital and surplus, December 31, current year	$8,669,946

AGGREGATE RESERVES FOR LIFE CONTRACTS	$23,258,534
CONTRACT CLAIMS – LIFE	$ 5,393,975

The majority of the Company's business is comprised of YRT life insurance products assumed from various direct writing companies. The Department performed a risk-focused actuarial analysis of reserving and reinsurance risks for the Company's assumed individual life insurance business. This included a review that:

- the reserve computations were performed correctly and the selected estimates were reasonable;
- the assumptions and methodologies used were accurate and appropriate;
- confirmed the statutory transfer of risk for retro-ceded reinsurance agreements; and
- claim loss data file was complete and accurate.

Information reviewed included the following:

- SSAE-16 internal control reports for claim processing and data collection and reporting;
- PwC actuarial and financial audit workpapers;
- 2016 Annual Statement; and
- 2016 Actuarial Opinion (Opinion) and Actuarial Memorandum (Memorandum).

The analysis of reserving risk analysis included:

- interviews with Company reserving actuaries responsible for conducting reserving and asset adequacy analysis;
- a review of the Opinion and Memorandum regarding cash flow testing, asset adequacy analysis, assumptions, and methodologies provided by the Company.

The analysis of reinsurance risks included:

- a review of material reinsurance treaties with respect to transfer of risk compliance with the CGS and the Manual.

Conclusion

Based upon the risk focused assessment and review, no material findings were noted which affected the Company's reserving and reinsurance risks.

COMMON CAPITAL STOCK	$2,500,000

The common capital stock of the Company consisted of 10,000 authorized and issued shares having a par value of $250 per share. All shares are owned by Chubb Group.

GROSS PAID IN AND CONTRIBUTED SURPLUS $39,930,275

The changes in the balance of this account in 2015 and 2016 were the result of capital contributions by the Company's parent in the amounts of $3,100,000 and $2,000,000, respectively.

UNASSIGNED FUNDS (SURPLUS) $(33,760,329)

During the period under examination, changes in surplus were the result of net income/(loss) from operations, and an adjustment to surplus reported for the year ending December 31, 2014, and 2015, resulting from a correction of an error for ceded reinsurance commissions and expense allowances and ceded reinsurance premiums, respectively.

CONCLUSION

The results of this examination disclosed that, as of December 31, 2016, the Company reported admitted assets of $51,706,821, liabilities of $43,036,875, and surplus of $8,669,946. During the period under examination, admitted assets increased $9,399,622, liabilities increased $9,316,593, and surplus as regards policyholders increased $83,029.

SIGNATURE

In addition to the undersigned, the following members of the Department participated in the examination: Cecilia Arnold, CFE; Michael Colburn, MAAA, FSA; Daniel Levine, AFE, CPA; Robert Linnell, CFE; Mark Murphy, CFE; and Kenneth Roulier, AFE, AES, CISA.

I, Thomas H. Corrigan, CFE, solemnly swear that the foregoing report on examination is hereby represented to be a full and true statement of the condition and affairs of the subject insurer as of December 31, 2016, to the best of my information, knowledge and belief.

Respectfully submitted,

Thomas H. Corrigan, CFE
Examiner-In-Charge
State of Connecticut
Insurance Department

State of Connecticut ss. Hartford

County of Hartford

Subscribed and sworn to before me, JOSEPH A. MEDINA
Notary Public on this 5TH day of MARCH, 2018.

Notary Public

JOSEPH A. MEDINA
NOTARY PUBLIC
MY COMMISSION EXPIRES Sept. 16, 2020

My Commission Expires

Examination Warrant Number 16-01186-69515-T1

Report of Limited-Scope Examination of

MedAmerica Insurance Company
Pittsburgh, Pennsylvania

As of December 31, 2016

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Harrisburg, Pennsylvania
June 21, 2018

Honorable Joseph DiMemmo, CPA
Deputy Insurance Commissioner
Commonwealth of Pennsylvania
Insurance Department
Harrisburg, Pennsylvania

Dear Sir:

In accordance with instructions contained in Examination Warrant Number 16-01186-69515-T1, dated July 11, 2017, a limited-scope examination was made of

MedAmerica Insurance Company, NAIC Code: 69515

a Pennsylvania domiciled, multi-state stock life insurance company, hereinafter referred to as the "Company" or "MAPA". The Company provides group and individual long-term care coverage. The examination was conducted primarily at the offices of the Pennsylvania Insurance Department ("Department") located in Harrisburg, Pennsylvania and the Philadelphia offices of Oliver Wyman Actuarial Consulting, Inc.

The Company discontinued sales as of February 15, 2016 and is not currently writing any new business. However, the Company continues to renew business and service existing policyholders as it runs off its long-term care book of business.

The last full-scope examination of the Company was conducted by the Department as of December 31, 2013. In that examination, the Department used the services of an independent consulting firm to provide an actuarial evaluation in support of reviewing the Company's carried reserves. Material deficiencies were identified in both the reported disabled life reserves and active life reserves. The Company agreed to book additional active and disabled life reserves as of the second quarter of 2015. The Company's ultimate controlling parent agreed to make a capital contribution to offset the reserve strengthening on surplus. Based upon these commitments, no financial adjustments were made as of December 31, 2013.

The Company reported net losses from operations of $4,216,258, $46,091,583 and $4,715,209 in each of the years 2014, 2015 and 2016, respectively. Also, the Company reported net income losses of $1,929,468, $45,776,336 and $1,154,033 respectively for each of these years.

The Department initiated this limited-scope examination with the assistance of a consulting actuary to examine the adequacy of the claim reserves and active life reserves reported by the Company as of December 31, 2016.

As this examination is limited in scope, this examination report is not intended to communicate all matters of importance for an understanding of the Company's financial condition. The format of this report is consistent with the current practices of the Department and the examination format prescribed by the National Association of Insurance Commissioners.

This report is limited to a brief description of the Company, a discussion of financial items that are of specific regulatory concern, and a factual disclosure of other significant regulatory information related to the active life reserves and claim reserves. The Report of Examination of the Company as of December 31, 2013, dated May 22, 2015, should be referred to for additional historical and background information.

A report of this limited-scope examination is hereby respectfully submitted.

SCOPE OF EXAMINATION

The Department has performed a limited-scope examination evaluating reserves and related experience through December 31, 2016.

John G. L. Giess Jr., FSA, MAAA, Chief Actuary of MedAmerica Insurance Company has served as the appointed actuary ("AA") for the Company since October 1, 2014. Mr. Giess prepared the Actuarial Opinions and Memoranda, Valuation Filings and Cash Flow Testing for the Company.

The Department engaged the assistance of an external consultant, Oliver Wyman Actuarial Consulting, Inc. ("OW"). Marc Lambright, FSA, MAAA, of OW was the primary actuary performing the analysis, referred to as "Consulting Actuary".

The Consulting Actuary performed the following procedures:

a. Review of in-force block characteristics:
   - Significant policy provisions and benefit language,
   - Counts, reserves, and premiums by age, block of business and policy grouping.

b. Review of experience analyses by block of business including mortality, lapse, behavior, and data related to exercising non-forfeiture options, claim incidence, claim terminations/duration, investment performance, etc.

c. Review of historical rate increase activity and the impact of this activity on policyholder behavior and experience, along with anticipated rate actions and the expected impact of these actions.

d. Review of claim reserve and liability assumptions and calculations, along with their consistency with MAPA actual and expected experience. This included disabled life reserves and IBNR, including provisions for any necessary claims adjustment expenses.

e. Review Actuarial Opinions and Memoranda to understand cash flow testing and assumptions and results of AA's testing to develop his Opinion related to reserves.

f. Review of Gross Premium Valuation projections and assumptions.

g. Review of Cash Flow Testing projections and assumptions.

h. Review of Department correspondence with MAPA and external consultant to understand previously identified areas of concern, permitted practices, prior

regulatory findings, etc., with a focus on work done to assess the returns, risks, and timing of cash flows associated with the investment portfolio, and an analysis of the reinsurance transactions with the Company's captive reinsurer MIG.

i. Discussions with MAPA and Department personnel to clarify/understand significant items related to the document review.

j. Review of Guaranty, Letter of Credit and Capital Support Agreements.

The Department and the Consulting Actuary participated in numerous discussions and a review meeting was held with senior management of the Company.

FINDINGS AND RECOMMENDATIONS

The Company reported aggregate reserves for accident and health contracts of $775,379,902, and a contract claims liability of $4,735,271 on its December 31, 2016 Annual Statement.

The Consulting Actuary documented their findings, conclusions and recommendations in a report to the Department finalized June 15, 2018. The Consulting Actuary report included the recommendation of an OW "base" reserve scenario and alternative scenarios, each of which indicated more adverse results than MAPA's base scenario.

Specifically, OW found that:

1. Many of the cash flow testing assumptions underlying the asset adequacy analysis appear to be optimistic relative to recent experience, even if they are consistent with experience over a longer time horizon.
2. Claim reserves have been inadequate over the past several years and the claim reserves as of December 31, 2016 do not appear to have been strengthened substantially.
3. The Company may not obtain, across all states, the rate increases assumed in the internal cash flow testing model.

The Department reviewed and accepted the work of the Consulting Actuary. Upon the Department's acceptance, the detailed findings were presented to and discussed with Company management, in a meeting led by the Department. The Company did not materially disagree with the overall conclusions from the Consulting Actuary but, recognized that because actuarial practice involves the estimation of uncertain events, there will often be a range of reasonable methods and assumptions.

SUBSEQUENT EVENTS

The Company's reported statutory surplus declined from $21,943,923 at December 31, 2016, to $21,392,978 on its December 31, 2017 Annual Statement. The Department observes this is an approximate $551,000 additional decrease in surplus. For the same time period, the Company's net income declined from $(1,154,033) to $(8,700,468).

CONCLUSION

Although each of the Consulting Actuary's scenarios produce less favorable results than the Company's base scenario, and indicate material reserve deficiencies, the Department is making no recommendation to change the financial statement at this time.

The Company has agreed to consider several long-term monitoring suggestions from the Consulting Actuary and incorporate those monitoring suggestions as needed into future reserve studies. The Department will continue to closely monitor the Company's financial condition and operating results.

The next regularly scheduled financial condition examination of the Company will cover the five-year period ending December 31, 2018.

This examination was managed by Philip Judge, CFE, with actuarial support provided primarily by Marc Lambright, FSA, MAAA.

Respectfully,

Melissa L. Greiner
Director
Bureau of Financial Examinations

Philip M. Judge, CFE
Examination Manager

The CFE designation has been conferred by an organization not affiliated with the federal or any state government. However, the CFE designation is the only designation recognized by the NAIC for the purposes of directing statutory Association examinations of insurance companies.

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

PEOPLE OF THE STATE OF ILLINOIS, *ex rel.*, JENNIFER HAMMER, DIRECTOR OF THE ILLINOIS DEPARTMENT OF INSURANCE, Plaintiff, v. PUBLIC SERVICE INSURANCE COMPANY, an Illinois domestic stock insurance company, and PUBLIC SERVICE MUTUAL HOLDING COMPANY, an Illinois domestic mutual holding company, Defendants.	)	Case No. 2017CH03790 CALENDAR/ROOM 05 TIME 00:00 Injunction

VERIFIED COMPLAINT FOR REHABILITATION

Plaintiff, THE PEOPLE OF THE STATE OF ILLINOIS, upon the relation of JENNIFER HAMMER, Director of the Illinois Department of Insurance (the "Director"), by and through their attorney, LISA MADIGAN, Attorney General of the State of Illinois, for their Verified Complaint for Rehabilitation against Defendants, Public Service Insurance Company and Public Service Mutual Holding Company, allege and state as follows:

JURISDICTION AND VENUE

1. This Verified Complaint is filed pursuant to the provisions of Article XIII of the Illinois Insurance Code (the "Code"), 215 ILCS 5/187, *et seq.*, which, *inter alia*, authorizes the Director to apply to this Court, through the Attorney General of the State of Illinois, on behalf of the People of the State of Illinois, for entry of an order to rehabilitate a domestic company upon a showing that any of the grounds for rehabilitation specified in Section 188 of the Code, 215 ILCS 5/188, exist.

2. Venue is proper in the Circuit Court of Cook County, Illinois pursuant to the provisions of Section 188 of the Code, 215 ILCS 5/188, and Section 2-101 of the Illinois Code of Civil Procedure, 735 ILCS 5/2-101.

PARTIES AND RELATED ENTITIES

3. Pursuant to the McCarran-Ferguson Act, 15 U.S.C. Section 1011, *et seq.*, the fifty states, the District of Columbia and the U.S. territories regulate the business of insurance, not the federal government. The Relator, Jennifer Hammer, is the Director of the Illinois Department of Insurance and, as such, is charged under Section 401 of the Code, 215 ILCS 5/401, with the rights, powers and duties appertaining to the enforcement and execution of all of the insurance laws of the State of Illinois. The Illinois Department of Insurance licenses, regulates, examines and, if appropriate, disciplines individuals and entities engaged in Illinois in the business of insurance. The Department's responsibilities include, but are not limited to, all aspects of insurance company solvency, the conduct of agents, brokers and companies, the collection of insurance taxes and assessments and, more broadly, the authority to regulate any individual or company involved with the management, distribution, sales or marketing of insurance or insurance-related matters in Illinois. On every topic, the Department's first priority is the protection of the people, families and businesses that purchase insurance in the State of Illinois.

4. Defendant, Public Service Insurance Company ("Public Service"), is a domestic stock insurance company organized under and existing by virtue of Article II of the Code, 215 ILCS 5/6, *et seq.* Public Service transacts the business of insurance as a property and casualty insurance company. Public Service's principal place of business is located at 10 South Riverside Plaza, Suite 875, Chicago, Illinois. Public Service was previously organized as a mutual

insurance company under Article III of the Code, 215 ILCS 5/36, *et seq.*, and is a "Converted Company" as that term is defined under Section 59.2(1)(a) of the Code, 215 ILCS 5/59.2(1)(a).

5. Defendant, Public Service Mutual Holding Company ("Public Service Mutual"), is an Illinois domestic mutual holding company organized under and existing by virtue of Article III of the Code, 215 ILCS 5/36, *et seq.*, having its principal place of business at 10 South Riverside Plaza, Suite 875, Chicago, Illinois. Public Service Mutual was formed as a result of the reorganization of Public Service as a stock insurance company. Pursuant to Section 59.2(1)(f)(v) of the Code, 215 ILCS 5/59.2(1)(f)(v), in any action initiated against Public Service under Article XIII of the Code, *supra*, Public Service Mutual's assets are subject to inclusion in the receivership estate of Public Service.

STATUTORY GROUNDS FOR REHABILITATION

6. Section 187 of the Code, 215 ILCS 5/187, provides, *inter alia,* that Article XIII of the Code, *supra*, applies to every corporation, association, society, order, firm, company, partnership, individual, and aggregation of individuals to which any article of the Code is applicable, or which is subject to examination, visitation or supervision by the Director under any provision of the Code or under any law of this State, or which is engaging in an insurance or surety business.

7. Section 188 of the Code, 215 ILCS 5/188, provides the grounds for rehabilitation and liquidation of a domestic company, as follows:

> Sec. 188. *Grounds for rehabilitation and liquidation of a domestic company.* . .
>
> Whenever any domestic company…
>
> * * *

13. consents by a majority of its directors, stockholders or members;

* * *

With respect to a domestic company, the Director must report,...any such case to the Attorney General of this State whose duty it shall be to apply forthwith by complaint on relation of the Director in the name of the People of the State of Illinois, as plaintiff, to the Circuit Court of Cook County ..., for an order to rehabilitate or liquidate the defendant company as provided in this article, and for such other relief as the nature of the case and the interests of its policyholders, creditors, members, or the public may require...

215 ILCS 5/188.

8. Based upon the investigation and discussions with the management and Board of Directors of Public Service and Public Service Mutual, relating to the business practices and financial condition of the Defendants, the Director has determined that conditions exist that would justify a court order for the rehabilitation of both Public Service and Public Service Mutual pursuant to Section 188 of the Code, *id.*, as follows:

On February 16, 2017, Public Service's Directors and Public Service Mutual's Directors unanimously passed corporate resolutions agreeing and consenting to the entry of an Agreed Order of Rehabilitation pursuant to Section 188 of the Code, waiving service of process of this Verified Complaint for Rehabilitation, and agreeing and consenting to waive any right to appear, answer or otherwise plead to this Verified Complaint and/or to appeal the Agreed Order of Rehabilitation prayed for herein. A copy of the Public Service Board of Directors' resolution is attached hereto as Exhibit A. A copy of the Public Service Mutual Board of Directors' resolution is attached hereto as Exhibit B.

9. As a result of her investigation, the Director has determined that the ground specified in Paragraph 7 herein exists with regard to both Public Service and Public Service Mutual and has determined that it is in the best interests of Public Service and Public Service

Mutual, their policyholders, claimants, creditors, and the public, that the Defendants, Public Service and Public Service Mutual, be placed into rehabilitation in accordance with Article XIII of the Code, *supra*.

WHEREFORE, the People of the State of Illinois, upon the relation of Jennifer Hammer, Director of the Illinois Department of Insurance, pray that an order be promptly entered by this Court as follows:

FINDING THAT:

(A) Sufficient cause exists for the entry of an order for rehabilitation of the Defendants, Public Service and Public Service Mutual, including the fact that their directors have unanimously agreed and consented to the entry of the order prayed for herein.

(B) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the entry of the order prayed for herein creates an estate comprising all of the liabilities and assets of Public Service and Public Service Mutual.

(C) Upon the entry of the Order prayed for herein, the Rehabilitator's statutory authority includes, without limitation, the following:

(i) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the Rehabilitator is vested by operation of law with the title to all property, contracts, and rights of action of Public Service and Public Service Mutual; and

(ii) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the Rehabilitator is entitled to immediate possession and control of all property, contracts, and rights of action of Public Service and Public Service Mutual; and

(iii) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the Rehabilitator is authorized to remove any and all records and property of Public Service and Public Service Mutual to her possession and control or to such other place as may be convenient for purposes of the efficient and orderly administration of the rehabilitation of Public Service and Public Service Mutual; and

(iv) Pursuant to Section 192(2) of the Code, 215 ILCS 5/192(2), the Rehabilitator is authorized to deal with the property, business and affairs of Public Service and Public Service Mutual in her name, as Director, and that the Rehabilitator is also authorized to deal with the property, business and affairs of Public Service and Public Service Mutual in the name of Public Service and Public Service Mutual; and

(v) Pursuant to Section 192(2) of the Code, 215 ILCS 5/192(2), the Rehabilitator, without the prior approval of the Court, is authorized to sell or otherwise dispose of any real or personal property of Public Service and Public Service Mutual, or any part thereof, and to sell or compromise all doubtful or uncollectible debts or claims owing to Public Service and/or Public Service Mutual having a value in the amount of Twenty-Five Thousand Dollars ($25,000.00), or less. Any such sale by the Rehabilitator of the real or personal property of Public Service and/or Public Service Mutual having a value in excess of Twenty-Five Thousand Dollars ($25,000.00), and sale or compromise of debts

owing to Public Service and/or Public Service Mutual where the debt owing to Public Service or Public Service Mutual exceeds Twenty-Five Thousand Dollars ($25,000.00) shall be made subject to the approval of the Court; and

(vi) Pursuant to Section 192(2) of the Code, 215 ILCS 5/192(2), the Rehabilitator may solicit contracts whereby a solvent company agrees to assume, in whole or in part, or upon a modified basis, the liabilities of a company in rehabilitation in a manner consistent with subsection (4) of Section 193 of the Code, 215 ILCS 5/193(4); and

(vii) Pursuant to Section 192(3) of the Code, 215 ILCS 5/192(3), the Rehabilitator is authorized to bring any action, claim, suit or proceeding against any person with respect to that person's dealings with Public Service and/or Public Service Mutual including, but not limited to, prosecuting any action, claim, suit, or proceeding on behalf of the policyholders, claimants, beneficiaries or creditors of Public Service and Public Service Mutual; and

(viii) Pursuant to Section 192(4) of the Code, 215 ILCS 5/192(4), if at any time the Rehabilitator finds that it is in the best interests of the policyholders, claimants, beneficiaries, and creditors to effect a plan of rehabilitation, the Rehabilitator may submit such a plan to the Court for its approval; and

(ix) Pursuant to Section 194(b) of the Code, 215 ILCS 5/194(b), the Rehabilitator may, within two (2) years after the entry of the rehabilitation order prayed for herein or within such further time as applicable law permits, institute an action, claim, suit, or proceeding upon any cause of action against which the

period of limitation fixed by applicable law had not expired as of the filing of the complaint upon which the rehabilitation order was entered; and

(x) Subject to the provisions of Section 202 of the Code, 215 ILCS 5/202, the Rehabilitator is authorized to appoint and retain those persons specified in Section 202(a) of the Code, 215 ILCS 5/202(a), and to pay, without the further order of this Court, from the assets of Public Service and Public Service Mutual, all administrative expenses incurred during the course of the rehabilitation of Public Service and Public Service Mutual; and

(xi) Pursuant to Section 203 of the Code, 215 ILCS 5/203, the Rehabilitator shall not be required to pay any fee to any public officer for filing, recording or in any manner authenticating any paper or instrument relating to any proceeding under Article XIII of the Illinois Insurance Code, 215 ILCS 5/187, *et seq.*, nor for services rendered by any public officer for serving any process; and

(xii) Pursuant to the provisions of Section 204 of the Code, 215 ILCS 5/204, the Rehabilitator may seek to avoid preferential transfers of the property of Public Service and Public Service Mutual and to recover such property or its value, if it has been converted.

ORDERING THAT:

(1) The Agreed Order of Rehabilitation prayed for herein is entered as to and against Public Service and Public Service Mutual.

(2) Jennifer Hammer, Director of the Illinois Department of Insurance, and her successors in office, is affirmed as the statutory Rehabilitator (the "Rehabilitator") of Public Service and Public Service Mutual with all of the powers appurtenant thereto.

(3) All policies and contracts of insurance, and agreements of reinsurance where Public Service is the ceding company, shall remain in full force and effect pending a determination by the Director as to when, and upon what terms, cancellation or renewal is appropriate. All treaties, contracts and agreements of reinsurance wherein Public Service was, or is, the assuming or retrocessional reinsurer shall also remain in full force and effect, until further order of the Court.

(4) Subject to the further orders of this Court, the Rehabilitator is authorized to take such actions as the nature of the cause and the interests of Public Service and Public Service Mutual, and their policyholders, claimants, beneficiaries, creditors, or the public may require including, but not limited to, the following:

(i) The Rehabilitator shall proceed to take immediate possession and control of the property, books, records, accounts, business and affairs, and all other assets of Public Service and Public Service Mutual, and of the premises occupied by Public Service and Public Service Mutual for the transaction of their business, and to marshal and liquidate the assets, business and affairs of Public Service and Public Service Mutual pursuant to the provisions of Article XIII of the Code, *supra,* and the Rehabilitator is further directed and authorized to orderly wind down and run off the business and affairs of Public Service and Public Service Mutual, and to make the continued expenditure of such wages, rents and expenses

as she may deem necessary and proper for the administration of the rehabilitation of Public Service and Public Service Mutual; and

(ii) The Rehabilitator may both sue and defend on behalf of Public Service and Public Service Mutual, or for the benefit of the policyholders, claimants and other creditors of Public Service and Public Service Mutual, in the courts either in her name as the Rehabilitator of Public Service and Public Service Mutual, or in the name of Public Service and/or Public Service Mutual, as the case may be; and

(iii) The Rehabilitator may continue to pay policyholder claims and claims against policyholders of Public Service as they come due. The Rehabilitator may also continue to pay assumed reinsurance claims as they come due.

(5) The Director is vested with the right, title and interest in all funds recoverable under contracts, treaties, certificates, and agreements of reinsurance heretofore entered into by or on behalf of Public Service.

(6) Any acts or omissions of the Rehabilitator in connection with the rehabilitation of Public Service and Public Service Mutual, shall not be construed or considered to be a preference within the meaning of Section 204 of the Code, 215 ILCS 5/204, notwithstanding the fact that any such act or omission may cause a policyholder, claimant, beneficiary, third party or creditor to receive a greater percentage of debt owed to or by Public Service and/or Public Service Mutual than any other policyholder, claimant, beneficiary, third party or creditor in the same class.

(7) The caption in this cause and all pleadings filed in this matter shall hereafter read:

"IN THE MATTER OF THE REHABILITATION OF PUBLIC SERVICE INSURANCE COMPANY AND PUBLIC SERVICE MUTUAL HOLDING COMPANY"

(8) All costs of the proceedings prayed for herein be taxed and assessed against the Defendants Public Service and Public Service Mutual.

(9) Pursuant to its authority under Section 189 of the Code, 215 ILCS 5/189, the Court hereby issues the following mandatory and prohibitive injunctions:

(i) All accountants, auditors and attorneys of Public Service and/or Public Service Mutual are ordered to deliver to the Rehabilitator, at her request, copies of all documents in their possession or under their control concerning or related to Public Service and/or Public Service Mutual, and to provide the Rehabilitator with such information as she may require concerning any and all business and/or professional relationships between them and Public Service and/or Public Service Mutual, and concerning any and all activities, projects, jobs and the like undertaken and/or performed by them at the request of Public Service and/or Public Service Mutual, or their agents, servants, officers, directors and/or employees, or which Public Service and/or Public Service Mutual may be, or is, entitled to as the result of their relationship with such accountants, auditors and attorneys; and

(ii) Public Service and Public Service Mutual and their directors, officers, agents, servants, representatives, employees, affiliated companies, and all other persons and entities, shall give immediate possession and control to the Rehabilitator of all property, business, books, records and accounts of Public Service and Public Service Mutual, and all premises occupied by Public Service and Public Service Mutual for the transaction of their business; and

(iii) Public Service and Public Service Mutual and their officers, directors, agents, servants, representatives and employees, affiliated companies, and all other persons and entities having knowledge of this Order are restrained and enjoined from transacting any business of Public Service and/or Public Service Mutual, or disposing of any company property or assets, including books, records and computer and other electronic data, without the express written consent of the Rehabilitator, or doing or permitting to be done any action which might waste the property or assets of Public Service and Public Service Mutual, until the further order of the Court; and

(iv) The officers, directors, agents, servants, representatives and employees of Public Service and Public Service Mutual, and all other persons and entities having knowledge of this Order are restrained and enjoined from bringing or further prosecuting any claim, action or proceeding at law or in equity or otherwise, whether in this State or elsewhere, against Public Service and/or Public Service Mutual, or their property or assets, or the Director as their Rehabilitator, except insofar as those claims, actions or proceedings arise in or are brought in the rehabilitation proceedings prayed for herein; or from obtaining, asserting or enforcing preferences, judgments, attachments or other like liens, including common law retaining liens, or encumbrances or the making of any levy against Public Service and/or Public Service Mutual, or their property or assets while in the possession and control of the Rehabilitator, or from interfering in any way with the Rehabilitator in her possession or control of the property, business,

books, records, accounts, premises and all other assets of Public Service and Public Service Mutual, until the further order of this Court; and

(v) Any and all banks, brokerage houses, financial institutions and any and all other companies, persons or entities having knowledge of this Order having in its possession accounts and any other assets which are, or may be, the property of Public Service and/or Public Service Mutual, are restrained and enjoined from disbursing or disposing of said accounts and assets and are further restrained and enjoined from disposing of or destroying any records pertaining to any business transaction between Public Service and/or Public Service Mutual, and such banks, brokerage houses, financial institutions, companies, persons or entities having done business, or doing business, with Public Service and/or Public Service Mutual, or having in their possession assets which are, or may be, the property of Public Service and/or Public Service Mutual, and further, that each such person or entity is ordered to immediately deliver any and all such assets and/or records to the Rehabilitator; and

(vi) All insurance and reinsurance companies and entities that assumed liabilities from Public Service arising under either contracts, policies of insurance, certificates of insurance, or agreements, contracts, treaties or certificates of reinsurance issued by Public Service, are restrained and enjoined from making any settlements with any claimant or policyholder of Public Service, or any other person other than the Rehabilitator, except with the written consent of the Rehabilitator, except when the reinsurance agreement, contract, treaty, or

certificate expressly and lawfully provides for payment by the reinsurer directly to a claimant or policyholder on the behalf of Public Service.

(10) The Court retains jurisdiction in this cause for the purpose of granting such other and further relief as the nature of this cause and the interests of Public Service and Public Service Mutual, their policyholders, claimants, beneficiaries and creditors, or of the public, may require and/or as the Court may deem proper in the premises.

Respectfully Submitted,

HELLIN JANG
Assistant Attorney General

Lisa Madigan
Attorney General of
The State of Illinois
Attorney for the PEOPLE OF
THE STATE OF ILLINOIS
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Counsel to the Director as Receiver
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Attorney Code 16819

VERIFICATION BY CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned, in her capacity as the Director of Illinois Department of Insurance, certifies that based upon her personal knowledge and/or documents, communications and other information made available to her as Director, the statements set forth in the foregoing Complaint are true and correct, except as to matters therein stated to be on information and belief, and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

DATED: March 16, 2017

JENNIFER HAMMER
Director of the Illinois
Department of Insurance

Exhibit A

RESOLUTION OF THE
BOARD OF DIRECTORS
OF
PUBLIC SERVICE INSURANCE COMPANY

February 16, 2017

WHEREAS, the Board of Directors of Public Service Insurance Company ("Public Service" or the "Company") acknowledges that a condition exists that would justify a court order for either rehabilitation or liquidation under Section 188 of the Code, 215 ILCS 5/188; and

WHEREAS, the Board recognizes that it is in the best interests of Public Service's policyholders that the Company be immediately placed into rehabilitation; and

WHEREAS, the Board of Directors of the Company does not oppose, and will not otherwise legally challenge, the entry by the Circuit Court of Cook County, Illinois (the "Supervising Court"), of an Agreed Order of Rehabilitation substantially in the form of the proposed order attached hereto as Exhibit A (the "Agreed Order of Rehabilitation"), against the Company and affirming the Director of Insurance of the State of Illinois as the statutory rehabilitator (the "Rehabilitator") of the Company; and

WHEREAS, the Board has been provided with a proposed plan of rehabilitation for review, a copy of which is attached hereto as Exhibit B (the "Plan"), and that the Board's consent to the entry of the Agreed Order of Rehabilitation is premised, in part, on the understanding that, subsequent to the entry of the Agreed Order of Rehabilitation and the preparation and finalization of the schedules referenced in the Plan, the Rehabilitator will present the Plan to the Supervising Court for approval; subject to a procedure of notice, comment and hearing.

NOW, THEREFORE, BE IT RESOLVED, that the Company, by unanimous vote of its Board of Directors, hereby ratifies, agrees and otherwise consents to the commencement of rehabilitation proceedings by way of the filing of a Verified Complaint for Rehabilitation under Section 188 of the Illinois Insurance Code, 215 ILCS 5/188, and the entry of the Agreed Order of Rehabilitation against the Company by the Circuit Court of Cook County; and

BE IT FURTHER RESOLVED, that the Company, by unanimous vote of its Board of Directors, agrees and irrevocably consents to waive service of process and any right to appear and answer or otherwise plead in response to the Verified Complaint for Rehabilitation; and

BE IT FURTHER RESOLVED, that the Company, unanimous vote of its Board of Directors, agrees and irrevocably consents to waive any right to appeal the Agreed Order of Rehabilitation; and

BE IT FURTHER RESOLVED, that the officers of the Company be and they hereby are authorized and directed, by unanimous vote of the Company's Board of Directors, to take all necessary and proper action on behalf of the Company to give full force and effect to the foregoing Resolutions; and

BE IT FURTHER RESOLVED that the recitals and prefatory phrases and paragraphs set forth above are incorporated in full as part of the foregoing Resolutions.

SECRETARY'S CERTIFICATE

The undersigned hereby certifies that he is the duly elected and qualified Secretary and the custodian of the books and records of Public Service Insurance Company, a domestic stock insurance company organized under and existing by virtue of the laws of the State of Illinois, and that the foregoing is a true record of a resolution duly adopted at a meeting of the Board of Directors and that said meeting was held in accordance with state law and the Bylaws of the above-named Corporation on February 16, 2017, and that said resolution is now in full force and effect without modification or rescission.

Public Service Insurance Company

Corporate Secretary

Date: February 17, 2017

ROSE M. HALBERT
NOTARY PUBLIC - STATE OF NEW YORK
NEW YORK COUNTY
LIC. #01HA4878071
COMMISSION EXPIRES 02/03/19

Subscribed and sworn to before me
this 17 day of February, 2017.

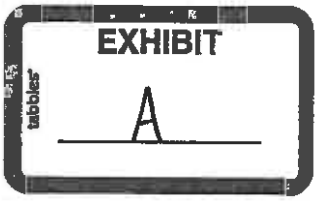
Notary Public

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

PEOPLE OF THE STATE OF ILLINOIS, *ex rel.*, JENNIFER HAMMER, DIRECTOR OF THE ILLINOIS DEPARTMENT OF INSURANCE,	)	
Plaintiff,	)	
v.	)	Case No.
PUBLIC SERVICE INSURANCE COMPANY, an Illinois domestic stock insurance company, and PUBLIC SERVICE MUTUAL HOLDING COMPANY, an Illinois domestic mutual holding company,	)	
Defendants.	)	

AGREED ORDER OF REHABILITATION

THIS CAUSE COMING TO BE HEARD upon the Verified Complaint for Rehabilitation filed herein by THE PEOPLE OF THE STATE OF ILLINOIS, upon the relation of JENNIFER HAMMER, Director of the Illinois Department of Insurance (the "Director" or "Rehabilitator"), seeking an Order of Rehabilitation as to and against Public Service Insurance Company ("Public Service") and Public Service Mutual Holding Company ("Public Service Mutual"), pursuant to the provisions of Article XIII of the Illinois Insurance Code (the "Code"), 215 ILCS 5/187, *et seq.* ("Article XIII"), the Court having jurisdiction over the parties hereto and the subject matter hereof, the Court having reviewed the pleadings filed herein and having considered arguments of counsel thereon, and the Court then being otherwise advised in the premises, and for good cause appearing therefore,



THE COURT FINDS THAT:

(A) Sufficient cause exists for the entry of an order for rehabilitation of the Defendants, Public Service and Public Service Mutual, including the fact that their directors have unanimously agreed and consented to the entry of an Agreed Order of Rehabilitation; and

(B) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the entry of this Agreed Order of Rehabilitation creates an estate comprising all of the liabilities and assets of Public Service and Public Service Mutual; and

(C) Upon the entry of this Agreed Order of Rehabilitation, the Rehabilitator's statutory authority includes, without limitation, the following:

(i) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the Rehabilitator is vested by operation of law with the title to all property, contracts, and rights of action of Public Service and Public Service Mutual; and

(ii) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the Rehabilitator is entitled to immediate possession and control of all property, contracts, and rights of action of Public Service and Public Service Mutual; and

(iii) Pursuant to Section 191 of the Code, 215 ILCS 5/191, the Rehabilitator is authorized to remove any and all records and property of Public Service and Public Service Mutual to her possession and control or to such other place as may be convenient for purposes of the efficient and orderly administration of the rehabilitation of Public Service and Public Service Mutual; and

(iv) Pursuant to Section 192(2) of the Code, 215 ILCS 5/192(2), the Rehabilitator is authorized to deal with the property, business and affairs of Public Service and Public Service Mutual in her name, as Director, and that the Rehabilitator is also authorized to deal with the property, business and affairs of Public Service and Public Service Mutual in the name of Public Service and Public Service Mutual; and

(v) Pursuant to Section 192(2) of the Code, 215 ILCS 5/192(2), the Rehabilitator, without the prior approval of the Court, is authorized to sell or otherwise dispose of any real or personal property of Public Service and Public Service Mutual, or any part thereof, and to sell or compromise all doubtful or uncollectible debts or claims owing to Public Service and/or Public Service Mutual having a value in the amount of Twenty-Five Thousand Dollars ($25,000.00), or less. Any such sale by the Rehabilitator of the real or personal property of Public Service and/or Public Service Mutual having a value in excess of Twenty-Five Thousand Dollars ($25,000.00), and sale or compromise of debts owing to Public Service and/or Public Service Mutual by the Rehabilitator where the debt owing to Public Service or Public Service Mutual exceeds Twenty-Five Thousand Dollars ($25,000.00) shall be made subject to the approval of the Court; and

(vi) Pursuant to Section 192(2) of the Code, 215 ILCS 5/192(2), the Rehabilitator may solicit contracts whereby a solvent company agrees to assume, in whole or in part, or upon a modified basis, the liabilities of a company in

rehabilitation in a manner consistent with subsection (4) of Section 193 of the Code, 215 ILCS 5/193(4); and

(vii) Pursuant to Section 192(3) of the Code, 215 ILCS 5/192(3), the Rehabilitator is authorized to bring any action, claim, suit or proceeding against any person with respect to that person's dealings with Public Service and/or Public Service Mutual including, but not limited to, prosecuting any action, claim, suit, or proceeding on behalf of the policyholders, claimants, beneficiaries or creditors of Public Service and Public Service Mutual; and

(viii) Pursuant to Section 192(4) of the Code, 215 ILCS 5/192(4), if at any time the Rehabilitator finds that it is in the best interests of the policyholders, claimants, beneficiaries, and creditors to effect a plan of rehabilitation, the Rehabilitator may submit such a plan to the Court for its approval; and

(ix) Pursuant to Section 194(b) of the Code, 215 ILCS 5/194(b), the Rehabilitator may, within two (2) years after the entry of this Agreed Order of Rehabilitation, or within such further time as applicable law permits, institute an action, claim, suit, or proceeding upon any cause of action against which the period of limitation fixed by applicable law had not expired as of the filing of the complaint upon which this rehabilitation order was entered; and

(x) Subject to the provisions of Section 202 of the Code, 215 ILCS 5/202, the Rehabilitator is authorized to appoint and retain those persons specified in Section 202(a) of the Code, 215 ILCS 5/202(a), and to pay, without the further order of his Court, from the assets of Public Service and Public Service Mutual, all

administrative expenses incurred during the course of the rehabilitation of Public Service and Public Service Mutual; and

(xi) Pursuant to Section 203 of the Code, 215 ILCS 5/203, the Rehabilitator shall not be required to pay any fee to any public officer for filing, recording or in any manner authenticating any paper or instrument relating to any proceeding under Article XIII of the Illinois Insurance Code, 215 ILCS 5/187, *et seq.*, nor for services rendered by any public officer for serving any process; and

(xii) Pursuant to the provisions of Section 204 of the Code, 215 ILCS 5/204, the Rehabilitator may seek to avoid preferential transfers of the property of Public Service and Public Service Mutual and to recover such property or its value, if it has been converted.

IT IS HEREBY ORDERED THAT:

(1) This Agreed Order of Rehabilitation is entered as to and against Public Service and Public Service Mutual.

(2) Jennifer Hammer, Director of the Illinois Department of Insurance, and her successors in office, is affirmed as the statutory Rehabilitator of Public Service and Public Service Mutual with all of the powers appurtenant hereto.

(3) All policies and contracts of insurance, and agreements of reinsurance where Public Service is the ceding company, shall remain in full force and effect pending a determination

by the Director as to when, and upon what terms, cancellation or renewal is appropriate. All treaties, contracts and agreements of reinsurance wherein Public Service was, or is, the assuming or retrocessional reinsurer shall remain in full force and effect, until further order of this Court.

(4) Subject to the further orders of the Court, the Rehabilitator is authorized to take such actions as the nature of the cause and the interests of Public Service and Public Service Mutual, and their respective policyholders, claimants, beneficiaries, creditors, or the public may require including, but not limited to, the following:

(i) The Rehabilitator shall proceed to take immediate possession and control of the property, books, records, accounts, business and affairs, and all other assets of Public Service and Public Service Mutual, and of the premises occupied by Public Service and Public Service Mutual for the transaction of their business, and to marshal and liquidate the assets, business and affairs of Public Service and Public Service Mutual pursuant to the provisions of Article XIII of the Code, *supra,* and the Rehabilitator is further directed and authorized to orderly wind down and run off the business and affairs of Public Service and Public Service Mutual, and to make the continued expenditure of such wages, rents and expenses as she may deem necessary and proper for the administration of the rehabilitation of Public Service and Public Service Mutual; and

(ii) The Rehabilitator may both sue and defend on behalf of Public Service and Public Service Mutual, or for the benefit of the policyholders, claimants and other creditors of Public Service and Public Service Mutual, in the courts in her

name as the Rehabilitator of Public Service and/or Public Service Mutual, or in the name of Public Service and/or Public Service Mutual, as the case may be; and

(iii) The Rehabilitator may continue to pay policyholder claims and claims against policyholders of Public Service as they come due. The Rehabilitator may also continue to pay assumed reinsurance claims as they come due.

(5) The Director is vested with the right, title and interest in all funds recoverable under contracts, treaties, certificates, and agreements of reinsurance heretofore entered into by or on behalf of Public Service.

(6) Any acts or omissions of the Rehabilitator in connection with the rehabilitation of Public Service and Public Service Mutual, shall not be construed or considered to be a preference within the meaning of Section 204 of the Code, 215 ILCS 5/204, notwithstanding the fact that any such act or omission may cause a policyholder, claimant, beneficiary, third party or creditor to receive a greater percentage of debt owed to or by Public Service and/or Public Service Mutual than any other policyholder, claimant, beneficiary, third party or creditor in the same class.

(7) The caption in his cause and all pleadings filed in his matter shall hereafter read:

"IN THE MATTER OF THE REHABILITATION OF PUBLIC SERVICE INSURANCE COMPANY AND PUBLIC SERVICE MUTUAL HOLDING COMPANY"

(8) All costs of these proceedings shall be taxed and assessed against the Defendants Public Service and Public Service Mutual.

(9) Pursuant to Section 189 of the Code, 215 ILCS 5/189, the Court hereby issues the following mandatory and prohibitive injunctions:

(i) All accountants, auditors and attorneys of Public Service and/or Public Service Mutual are ordered to deliver to the Rehabilitator, at her request, copies of all documents in their possession or under their control concerning or related to Public Service and/or Public Service Mutual, and to provide the Rehabilitator with such information as she may require concerning any and all business and/or professional relationships between them and Public Service and/or Public Service Mutual, and concerning any and all activities, projects, jobs and the like undertaken and/or performed by them at the request of Public Service and/or Public Service Mutual, or its agents, servants, officers, directors and/or employees, or which Public Service and/or Public Service Mutual may be, or is, entitled to as the result of their relationship with such accountants, auditors and attorneys; and

(ii) Public Service and Public Service Mutual and their directors, officers, agents, servants, representatives, employees, affiliated companies, and all other persons and entities, shall give immediate possession and control to the Rehabilitator of all property, business, books, records and accounts of Public Service and Public Service Mutual, and all premises occupied by Public Service and Public Service Mutual for the transaction of their business; and

(iii) Public Service and Public Service Mutual and their officers, directors, agents, servants, representatives and employees, affiliated companies and all other persons and entities having knowledge of this Order are restrained and enjoined from transacting any business of Public Service and/or Public Service Mutual, or disposing of any company property or assets, including books, records and computer and other electronic data, without the express written consent of the Rehabilitator, or doing or permitting to be done any action which might waste the property or assets of Public Service and Public Service Mutual, until the further order of this Court; and

(iv) The officers, directors, agents, servants, representatives and employees of Public Service and Public Service Mutual, and all other persons and entities having knowledge of this Order are restrained and enjoined from bringing or further prosecuting any claim, action or proceeding at law or in equity or otherwise, whether in his State or elsewhere, against Public Service and/or Public Service Mutual, or its property or assets, or the Director as its Rehabilitator, except insofar as those claims, actions or proceedings arise in or are brought in these rehabilitation proceedings; or from obtaining, asserting or enforcing preferences, judgments, attachments or other like liens, including common law retaining liens, or encumbrances or the making of any levy against Public Service and/or Public Service Mutual, or its property or assets while in the possession and control of the Rehabilitator, or from interfering in any way with the Rehabilitator in her possession or control of the property, business, books, records, accounts, premises and all other assets of Public Service and Public Service Mutual, until

the further order of this Court; and

(v) Any and all banks, brokerage houses, financial institutions and any and all other companies, persons or entities having knowledge of this Order having in its possession accounts and any other assets which are, or may be, the property of Public Service and/or Public Service Mutual, are restrained and enjoined from disbursing or disposing of said accounts and assets and are further restrained and enjoined from disposing of or destroying any records pertaining to any business transaction between Public Service and/or Public Service Mutual, and such banks, brokerage houses, financial institutions, companies, persons or entities having done business, or doing business, with Public Service and/or Public Service Mutual, or having in their possession assets which are, or may be, the property of Public Service and/or Public Service Mutual, and further, that each such person or entity is ordered to immediately deliver any and all such assets and/or records to the Rehabilitator; and

(vi) All insurance and reinsurance companies and entities that assumed liabilities from Public Service arising under either contracts, policies of insurance, certificates of insurance, or agreements, contracts, treaties or certificates of reinsurance issued by Public Service, are restrained and enjoined from making any settlements with any claimant or policyholder of Public Service, or any other person other than the Rehabilitator, except with the written consent of the Rehabilitator, except when the reinsurance agreement, contract, treaty, or certificate expressly and lawfully provides for payment by the reinsurer directly to a claimant or policyholder on behalf of Public Service.

(10) This Court retains jurisdiction in this cause for the purpose of granting such other and further relief as the nature of this cause and the interests of Public Service and Public Service Mutual, its policyholders, claimants, beneficiaries and creditors, or of the public, may require and/or as this Court may deem proper in the premises.

(11) This cause is set for status on _____, 2017 at _____.

ENTERED:

_____
Judge Presiding

Lisa Madigan
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The State of Illinois
Attorney for the PEOPLE OF
THE STATE OF ILLINOIS
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AGREED TO BY:

_____
Hellin Jang, Assistant Attorney General on behalf of
The People of the State of Illinois, *ex rel.*, Jennifer
Hammer, Director of the Illinois Department of Insurance

_____
Thomas D. Cunningham, Sidley Austin LLP on behalf of
Public Service Insurance Company, an Illinois domestic
stock insurance company, and Public Service Mutual
Holding Company, an Illinois domestic mutual holding
company

PLAN OF REHABILITATION FOR

PUBLIC SERVICE INSURANCE COMPANY

And

PUBLIC SERVICE MUTUAL HOLDING COMPANY

Public Service Insurance Company and its ultimate parent, Public Service Mutual Holding Company, were placed in rehabilitation pursuant to the provisions of Article XIII, 215 ILCS 5/187 *et seq.*, of the Illinois Insurance Code, 215 ILCS 5/1 *et seq.*, on _____, 2017 by entry of an Agreed Order of Rehabilitation by the Circuit Court of Cook County, Illinois. Jennifer Hammer, Acting Director of the Illinois Department of Insurance and her successors in office, was affirmed as their statutory rehabilitator, pursuant to the provisions of Article XIII. This Plan of Rehabilitation is intended to ratably allocate the available assets of PSIC and PSMHC to pay the financial obligations of PSIC and PSMHC as they come due throughout the duration of this Plan of Rehabilitation, subject to the statutory schedule of priorities as set forth in Section 205(1), 215 ILCS 5/205(1), of the Code.

PART I Definitions

1.01 Annual Report: An annual report delivered by the Rehabilitator to the Supervising Court regarding the Estates and the Rehabilitation.

1.02 Annual Statement: The 2016 audited statutory financial statement of PSIC, as filed with the Illinois Department of Insurance.

1.03 Article XIII: Article XIII of the Code, 215 ILCS 5/187-221.13.

1.04 Attorney-in-Fact: A person holding a written power of attorney from the Director, as Rehabilitator, authorizing them to act as her agent and in her name.

1.05 Claim: An assertion of a right to share in a distribution of General Assets.

1.06 Claimant: Any person or entity who makes a Claim.

1.07 Code: The Illinois Insurance Code, 215 ILCS 5/1 *et seq.*

1.08 Director: The Director of the Illinois Department of Insurance.

1.09 Discontinued Assumed Reinsurance: A product line of business written by PSIC that assumed exposure written by third party insurers during a period that covers approximately 1962 through and including 1986.

1.10 Employees of PSIC and PSMHC: Those persons who were employed by PSIC or PSMHC at the time the Rehabilitation Order was entered.

1.11 Estates: The rehabilitation estates of PSIC and PSMHC.

1.12 Existing Management: The management, acting under the supervision and control of the Rehabilitator, of PSIC and PSMHC as of the business day immediately prior to the Plan Effective Date.

1.13 General Assets: The respective assets of the separate estates of PSIC and PSMHC, whether real or personal, that are not specifically mortgaged, pledged, deposited as security or otherwise encumbered; and with respect to encumbered property, the term includes all such property in excess of the amount necessary to discharge the sum or sums secured. Pursuant to Section 59.2(1)(f)(v), 215 ILCS 5/59.2(1)(f)(v), of the Code, the assets of PSMHC are subject to inclusion in the estate assets of PSIC.

1.14 LPT Subject Business: All business ceded pursuant to the Technology LPT Agreement or the Terminal LPT.

1.15 PBGC: The Pension Benefit Guaranty Corporation.

1.16 Plan: This Plan of Rehabilitation for Public Service Insurance Company and Public Service Mutual Holding Company, as approved by the Supervising Court.

1.17 Plan Effective Date: The date on which the Supervising Court entered an order approving the Plan.

1.18 PSMHC: Public Service Mutual Holding Company, in Rehabilitation.

1.19 PSIC: Public Service Insurance Company, in Rehabilitation. References to PSIC herein shall include PSIC in its capacity as the legal successor to any and all entities merged into it at any time.

1.20 PSIC Indemnitees: has the meaning specified in Paragraph 12.01.

1.21 PSIC Pension Plan: The qualified, defined benefit pension plan for PSIC employees.

1.22 Rehabilitation: The receivership proceedings commenced against PSIC and PSMHC upon the entry of the Rehabilitation Order.

1.23 Rehabilitation Date: _____, 2017.

1.24 Rehabilitation Order: The agreed order of rehabilitation entered by the Supervising Court on _____, 2017.

1.25 Rehabilitator: Jennifer Hammer, Acting Director of the Illinois Department of Insurance, and any successors in office, acting solely in their capacity as the statutory and court affirmed Rehabilitator of PSIC and PSMHC.

1.26 Retained Business: All business written or assumed by PSIC (or any company merged into PSIC) other than the LPT Subject Business.

1.27 Special Deputy: The Office of the Special Deputy Receiver.

1.28 Supervising Court: The Circuit Court of Cook County, Illinois, County Department, Chancery Division, before which the Rehabilitation is pending, or the presiding judge in such proceeding.

1.29 Supplemental Pension Plan: A supplemental pension plan for certain former PSIC employees.

1.30 Surplus Noteholders: Holders of the surplus notes issued by PSIC's legal predecessor, Public Service Mutual Insurance Company.

1.31 Technology: Technology Insurance Company, Inc.

1.32 Technology LPT Agreement: The loss portfolio transfer agreement, effective as of March 11, 2016, entered into by and among PSIC, WSIC and Technology.

1.33 Terminal LPT: A proposed loss portfolio transfer by and between PSIC and a third party reinsurer ceding all or certain business written or assumed by PSIC that was not previously ceded to Technology under the Technology LPT Agreement.

1.34 Terminal LPT Counterparty: The third party reinsurer with respect to the Terminal LPT, if any.

1.35 WSIC: Western Select Insurance Company, an Illinois-domiciled insurance company that is a wholly-owned direct subsidiary of PSIC.

Part II Powers Of The Rehabilitator

2.01 This Plan incorporates, without limitation, the statutory provisions of Article XIII, and nothing in this Plan shall negate or diminish the Rehabilitator's authority and powers as set forth in Article XIII.

2.02 The Rehabilitator shall have the power to exercise, pursue or avail herself of any lawful right, power or remedy as is necessary or proper to implement this Plan, including, but not limited to, the power:

(a) to reserve or utilize General Assets to:

(i) pay the respective costs and expenses of the Estates' administration;

(ii) meet the Estates' obligations under this Plan; and

(iii) make investments as the Rehabilitator deems appropriate and prudent;

(b) to acquire, sell, transfer, abandon or otherwise dispose of, or deal with, General Assets upon such terms and conditions as are reasonable;

(c) to execute, acknowledge and deliver any documents or instruments necessary or proper to effectuate any transaction;

(d) to enter into such contracts as the Rehabilitator deems necessary or proper to implement this Plan, and, to affirm, modify or disavow any contracts to which PSIC or PSMHC is or may be a party; and

(e) to institute and pursue, in the name, or names, of PSIC and PSMHC or in the Rehabilitator's own name, subject to Paragraph 12.03 of this Plan, any and all suits and other legal proceedings and remedies before the Supervising Court or in any other forum or jurisdiction, and to assert all available claims and defenses.

Part III Administration

3.01 Unless otherwise noted, each section of this Plan shall be applicable throughout the duration of this Plan, subject to the further order of the Supervising Court.

3.02 The Rehabilitator is authorized to pay out of General Assets all costs and expenses of the Estates' administration including, but not limited to, salaries and the employment-related benefits of Existing Management and all Employees of PSIC and PSMHC, but excluding the Estates' executive severance obligations. Attached hereto as Schedule 3.02 is a schedule of all such employee-related benefits owing to Existing Management and Employees of PSIC and PSMHC as of December 31, 2016.

3.03 The Rehabilitator is authorized and directed to purchase the maximum available extended reporting period coverage for PSIC and PSMHC under the D&O insurance policies in force on the business day immediately preceding the Plan Effective Date. All costs, fees and taxes arising from or related to this purchase shall be paid as administrative expenses.

3.04 The costs and expenses of administration shall be reported by the Rehabilitator in quarterly financial statements, quarterly *Statements of Changes in Cash and Invested Assets* prepared in accordance with Section 202(d), 215 ILCS 5/202(d),

of the Code, annual financial statements, and the Annual Report to the Supervising Court.

3.05 From time to time, the Rehabilitator may appoint or employ consultants, accountants, assistants and attorneys to assist her in the Rehabilitation and the implementation and effectuation of this Plan. Subject to the requirements of Section 202(a), 215 ILCS 5/202(a), of the Code, the Rehabilitator shall pay the compensation of all such consultants, accountants, assistants and attorneys, as well as the compensation of the Special Deputy, Attorney-in-Fact, and their staff, out of General Assets, and shall report such payments to the Supervising Court in the Annual Report. Any compensation the Rehabilitator pays accountants retained to perform an annual audit of, and/or other services with respect to, PSIC and PSMHC, pursuant to Section 200, 215 ILCS 5/200, of the Code, shall be reported to the Supervising Court in the Annual Report.

3.06 The Rehabilitator may sell any General Asset to pay:

(a) the costs and expenses of the Estates' administration;

(b) the compensation of her attorneys, senior attorneys, accountants, assistants, consultants, Special Deputy, Attorney-in-Fact, and their staff; or

(c) the obligations of the Estates as provided in this Plan.

Approval of this Plan shall constitute the approval and direction of the Supervising Court pursuant to Section 192, 215 ILCS 5/192(2), of the Code. The Rehabilitator shall report the sale of any General Asset to the Supervising Court in the Annual Report. Attached hereto as Schedule 3.06 is a schedule of the respective assets of PSIC and PSMHC, including both the unencumbered General Assets and encumbered assets as of December 31, 2016, as reflected on the Annual Statement.

3.07 Payment of the respective liabilities of PSIC and PSMHC shall be made ratably pursuant to the statutory schedule of priorities as set forth in Section 205(1), 215 ILCS 5/205(1), of the Code. Attached hereto as Schedule 3.07 is a schedule of the respective liabilities of PSIC and PSMHC as of December 31, 2016, as reflected on the Annual Statement.

3.08 Where economically feasible, the Rehabilitator will continue to marshal assets that may be due to PSIC and/or PSMHC and will make such assets available for the payment of administrative expenses and Claims.

3.09 The injunctive provisions contained in the Rehabilitation Order shall continue in full force and effect, unless otherwise provided under this Plan and subject to the further order of the Supervising Court.

Part IV Administration of Claims Asserted Under Insurance Policies

4.01 PSIC will continue to administer all Claims (other than Claims with respect to the LPT Subject Business) asserted under policies of insurance issued by PSIC, or any insurer merged into PSIC. Such administration shall include, among other things, the settlement, defense, and payment of all such Claims.

4.02 Both policyholders and persons asserting causes of action against such policyholders shall present their Claims to the Rehabilitator in a manner consistent with Section 209(1), 215 ILCS 5/209(1), of the Code. Claims pending with PSIC, as reflected on its books and records, on the Plan Effective Date need not be re-presented to the Rehabilitator. Attached hereto as Schedule 4.02 is a schedule of the gross reserves with respect to PSIC's direct business, by line of business, as of December 31, 2016, net of the business reinsured pursuant to the Technology LPT Agreement, as reflected on the Annual Statement. PSIC has also provided the Director with an electronic file listing all of its open claims with respect to such business (other than claims reinsured pursuant to the Technology LPT Agreement) as of December 31, 2016.

4.03 In the event the Rehabilitator determines that any such Claim cannot be settled by way of a mutually acceptable resolution between the Rehabilitator and the claimant, then the Rehabilitator may implement the hearing provisions of Section 209(11)(b), 215 ILCS 5/209(11)(b), of the Code.

4.04 Payments made on Claims under the Retained Business asserted under policies of insurance issued by PSIC, or any insurer merged into PSIC, by policyholders or persons asserting causes of action against such policyholders shall be reported to the Supervising Court in the Annual Report.

4.05 Subject to the further order of the Supervising Court, PSIC shall continue to provide a policy defense to insureds under policies for which it remains liable, the costs of which shall constitute an administrative expense of the Estates.

4.06 The Rehabilitator is authorized to delay, suspend, or cease any payments called for under this section of this Plan without further notice or order of the Supervising Court in the event she makes a written determination that PSIC's financial condition will not support the payment, in full, of Claims arising or that may arise with respect to the Retained Business. In the event that the Rehabilitator makes such a determination, and the delay, suspension, or cessation of payments continues for more than ninety (90) days, the Rehabilitator shall report such determination to the Supervising Court and request that the Supervising Court approve the appropriate amendment or modification to, or dissolution of, the Plan, with such notice to policyholders and known Claimants as the Supervising Court directs.

Part V Settlements and Commutations

5.01 The Rehabilitator, in her sole discretion, may compromise and settle, in writing, all doubtful, disputed or uncollectible debts or claims owing to or by PSIC or PSMHC, and shall report the same to the Supervising Court in the Annual Report. Any debt or Claim having an individual value of $250,000.00 or more, which the Rehabilitator deems should be compromised or settled in the best interests of PSIC and/or PSMHC and their respective Claimants, shall be submitted to the Supervising Court for its approval. Payment of any such compromised or settled debt or claim shall be made from the General Assets of PSIC or PSMHC, as the case may be. With respect to debts or claims having an individual value of less than $250,000.00, which the Rehabilitator deems should be compromised or settled in the best interests of PSIC and/or PSMHC and their respective Claimants, approval of this Plan by the Supervising Court shall constitute the approval and direction of the Supervising Court pursuant to Section 192(2), 215 ILCS 5/192(2), of the Code. Attached hereto as Schedule 5.01 is a schedule of all debts or claims (whether undisputed, doubtful, disputed or uncollectible) owing to or by PSIC or PSMHC as of December 31, 2016, as reflected on the Annual Statement.

5.02 Other than with respect to the Whole Account Adverse Loss Development Reinsurance Agreement, dated May 28, 2014, by and among PSMHC, PSIC, WSIC and Munich Reinsurance America, Inc., the Rehabilitator may, in her sole discretion, attempt the voluntary commutation of any or all reinsurance agreements wherein PSIC and/or PSMHC ceded a portion of its liability to any reinsurer or wherein PSIC and/or PSMHC assumed any risk, liability or obligation from a cedent. Any commutation having an individual value of $250,000.00 or more, which the Rehabilitator deems commercially reasonable and should be executed in the best interests of PSIC and/or PSMHC and their Claimants, shall be submitted to the Supervising Court for its approval. Any payment due from PSIC and/or PSMHC to a cedent or reinsurer pursuant to any such compromised or settled debt or Claim shall be paid from the General Assets of PSIC or PSMHC, as the case may be. With respect to any commutation having an individual value of less than $250,000.00, which the Rehabilitator deems commercially reasonable and should be executed in the best interests of PSIC and/or PSMHC and their Claimants, approval of this Plan shall constitute the approval and direction of the Supervising Court pursuant to Section 192(2), 215 ILCS 5/192(2), of the Code.

Part VI Other Liabilities

6.01 As set forth above in Paragraph 3.07, payment of the respective liabilities of PSIC and PSMHC shall be made ratably pursuant to the statutory schedule of priorities as set forth in Section 205(1), 215 ILCS 5/205(1), of the Code.

6.02 Notwithstanding anything to the contrary contained herein, the Rehabilitator may, in her sole discretion, pay Claims of lower priority Claimants of the Estates prior

to having paid all higher priority level Claims in full if, in her reasonable judgment, she determines that: (i) all higher priority level Claims are adequately reserved for; and (ii) all Claims situated at the same priority level as any such "lower priority level Claimant" to receive payment under this Paragraph 6.02 are adequately reserved for, such that those Claims will be paid ratably with any Claims at the same priority level paid at an earlier point in time under the Plan.

6.03 Prior to the termination of the PSIC Pension Plan, the Rehabilitator is authorized and directed to use her best efforts to pay the minimum quarterly contribution amounts due to the PSIC Pension Plan in full as they become due and owing.

6.04 The Rehabilitator is authorized to: (i) reach a settlement with the PBGC regarding the unfunded PSIC Pension Plan obligations; and (ii) terminate the PSIC Pension Plan.

6.05 The Estates' contractual executive severance obligations are fixed pursuant to Section 194, 215 ILCS 5/194, of the Code as of the date of entry of the Rehabilitation Order. The Rehabilitator is authorized to pay the Estates' contractual executive severance obligations, which constitute general creditor Claims under the statutory schedule of priorities, 215 ILCS 5/205(1)(g). Attached hereto as Schedule 6.05 is a schedule of the Estates' executive severance obligations. Payment of the executive severance obligations shall become due as follows:

(A) The Rehabilitator is authorized to pay the unpaid balance of the executive severance obligations at any time pursuant to the provisions of Paragraph 6.02.

(B) Notwithstanding Paragraph 6.05(A), within ten (10) business days following the Plan Effective Date, the Rehabilitator will issue an initial cash payment to each executive possessing a Claim based upon a contractual right of severance representing 25% of the severance obligation due each such executive. The aggregate amount of these payments being $[•].

(C) Notwithstanding Paragraph 6.05(A), if a loss portfolio transfer is consummated following the Plan Effective Date which effectuates the transfer to, and assumption by, one or more third party reinsurers of the claim liability and exposure with respect to all or substantially all direct voluntary business remaining on PSIC's books and records, the unpaid balance of the executive severance obligations shall become due thirty (30) calendar days following the closing of such loss portfolio transfer. For purposes of this Paragraph 6.05(C), the term "substantially all" shall mean no less than approximately 90% of all direct voluntary business on PSIC's books and records immediately prior to the closing of such loss portfolio transfer.

6.06 The claim of the PBGC against the Estates is fixed in the amount of $[•] and payment by the Rehabilitator to the PBGC in said amount shall constitute a full and final satisfaction and release of all existing and future PSIC Pension Plan obligations owing to the PBGC with respect to said PSIC Pension Plan.

6.07 The Rehabilitator is authorized and directed to use her best efforts to pay the annual contribution amounts due to beneficiaries of the Supplemental Pension Plan and is authorized to negotiate a terminal settlement with any such beneficiaries and terminate the Supplemental Pension Plan. All payments made under this Paragraph 6.07 constitute general creditor Claims under the statutory schedule of priorities, 215 ILCS 5/205(1)(g). Claims due to beneficiaries of the Supplemental Pension Plan are payable only (i) after all higher priority level Claims under Section 205(1), 215 ILCS 5/205(1), have been paid in full, or (ii) pursuant to Paragraph 6.02, after such Claims have been adequately reserved for. Attached hereto as Schedule 6.07 is a schedule of all the annual contribution amounts due each beneficiary of the Supplemental Pension Plan as of December 31, 2016.

6.08 The Rehabilitator is authorized, subject to the Supervising Court's approval, to fix the liabilities arising under the Retained Business either by way of commutation or in a manner consistent with Sections 209(7) and (11)(b), 215 ILCS 5/209(7) and (11)(b), of the Code. All such liabilities as fixed by the Rehabilitator and approved by the Supervising Court shall be paid from the General Assets of PSIC. Attached hereto as Schedule 6.08 is a schedule of the gross reserves with respect to the Discontinued Assumed Reinsurance and business written or assumed by PSIC with respect to state-mandated pools or associations as reflected on PSIC's books and records as of December 31, 2016, as reflected on the Annual Statement.

6.09 The claims of Surplus Noteholders are payable only (i) after all higher priority level Claims under Section 205(1), 215 ILCS 5/205(1), have been paid in full, or (ii) pursuant to Paragraph 6.02, after such Claims have been adequately reserved for. Attached hereto as Schedule 6.09 is a schedule of the amounts owed to the Surplus Noteholders as of December 31, 2016, as reflected on the Annual Statement.

Part VII Other Transactions

7.01 The Rehabilitator is authorized to negotiate, subject to the approval of the Supervising Court, a Terminal LPT with a Terminal LPT Counterparty. The Rehabilitator is authorized to engage, among others, senior members of Existing Management to negotiate the Terminal LPT. Attached hereto as Schedule 7.01 is a schedule of the gross reserves on PSIC's books and records, as of December 31, 2016, with respect to all business that it is anticipated will be ceded to the Terminal LPT Counterparty pursuant to the Terminal LPT, as reflected on the Annual Statement.

Part VIII Inuring Reinsurance

8.01 Except as otherwise contained in this Plan or as inconsistent with the applicable provisions of Article XIII, reinsurers shall retain the rights and obligations contained in their respective reinsurance agreements with PSMHC and PSIC.

Part IX No Preferences

9.01 No act or omission of, by or made on behalf of the Rehabilitator in connection with the Rehabilitation shall be construed or considered to be a preference within the meaning of Section 204, 215 ILCS 5/204, of the Code or a fraudulent transfer under the Uniform Fraudulent Transfer Act, notwithstanding the fact that any such act or omission may cause a Claimant to receive a greater percentage of debt owed by PSIC or PSMHC than any other Claimant in the same priority established under Section 205(1), 215 ILCS 5/205, of the Code. Nothing in this Plan shall be deemed to cause any Claimant to have any greater Claim than that which they would have had if the Rehabilitation Order or this Plan had not been entered.

Part X Rights of Set-Off and Counterclaim

10.01 Subject to the provisions of any reinsurance agreement or other written agreement between PSIC and/or PSMHC and their respective Claimants or reinsurers, and subject to the provisions of Section 206, 215 ILCS 5/206, of the Code, any Claimant and/or reinsurer may assert any set-off or counterclaim against PSIC and/or PSMHC, provided (i) there is mutuality, (ii) the obligation sought to be set off or counterclaimed has been actually paid or deemed to be absolute (with the sole exception of any premium owed by PSIC and/or PSMHC to any cedent or reinsurer), and (iii) the Rehabilitator has been given written notice of such set-off or counterclaim.

10.02 Subject to the provisions of any reinsurance agreement or other written agreement between PSIC and/or PSMHC and their Claimants and/or reinsurers and subject to the provisions of Section 206, 215 ILCS 5/206, of the Code, PSIC and PSMHC may assert any set-off or counterclaim against any Claimant or reinsurer.

Part XI Secured Parties

11.01 Secured Claimants may surrender their security and participate *pro rata* with unsecured Claimants in any payments from General Assets made by the Rehabilitator subsequent to such surrender. Any secured Claimant who discharges any obligation owed to it by PSIC and/or PSMHC by resort to such security, but whose obligation owed by PSIC and/or PSMHC is not fully discharged by such resort to security, shall be paid the balance of such obligation by the Rehabilitator *pro rata* with all unsecured Claimants pursuant to the provisions of this Plan, provided that such secured Claimant has given proper written notice of such balance to the Rehabilitator.

Part XII Liability Exclusion and Indemnification

12.01 Neither PSIC or PSMHC, their respective officers, directors, members, employees, agents, consultants or attorneys (the "PSIC Indemnitees"), nor the Rehabilitator, her staff, employees, agent, consultants or attorneys shall have any liability to any Claimant or reinsurer, or to any of their respective creditors, assigns, representatives or receivers, for any act or omission in connection with the formulation, preparation, adoption, description, explanation or implementation of this Plan, including without limitation:

(a) inaccuracy of any information delivered to the Rehabilitator by a Claimant;

(b) tardy delivery of any report from a Claimant to PSIC and/or PSMHC or from PSIC and/or PSMHC to a reinsurer pursuant to this Plan;

(c) failure to pursue or collect any sums due PSIC and/or PSMHC from any Claimant, reinsurer, or other person or entity; or

(d) failure to audit, investigate, supervise or defend any Claim or obligation insured by or ceded to PSIC and/or PSMHC.

12.02 The exculpation and indemnification provisions and obligations in the articles of incorporation and by-laws of PSIC and PSMHC shall survive after the Plan Effective Date and shall not be amended during the pendency of this Plan.

12.03 With respect to any liability arising from or associated with any act or omission taken under the written direction and control, or with the written consent, of the Illinois Department of Insurance, from August 10, 2016 to the Rehabilitation Date, the PSIC Indemnitees shall be exculpated to the greatest extent legally permitted. Without limiting the generality of the foregoing, none of the PSIC Indemnitees shall have any liability to PSIC, any Claimant or reinsurer, or to any of their respective creditors, members, policyholders, assigns, representatives or receivers that had notice of this Plan and an opportunity to object to its entry, for any act or omission that is taken under the written direction and control, or with the written consent, of the Illinois Department of Insurance.

12.04 With respect to any liability arising from or associated with any act or omission taken under the written direction and control, or with the written consent, of the Rehabilitator, the PSIC Indemnitees shall be exculpated to the greatest extent legally permitted. Without limiting the generality of the foregoing, none of the PSIC Indemnitees shall have any liability to PSIC, any Claimant or reinsurer, or to any of their respective creditors, members, policyholders, assigns, representatives or receivers that had notice of this Plan and an opportunity to object to its entry, for any act or omission that is taken under the written direction and control, or with the written consent, of the Rehabilitator.

12.05 Any indemnification obligation payable under the articles of incorporation or by-laws of PSIC and PSMHC or pursuant to this Part XII with respect to acts or omissions occurring prior to the Plan Effective Date shall constitute general creditor Claims under the statutory schedule of priorities, 215 ILCS 5/205(1)(g), and shall be paid only (i) after all higher priority level Claims under Section 205(1), 215 ILCS 5/205(1), have been paid in full, or (ii) pursuant to Paragraph 6.02, after such Claims have been adequately reserved for. Any indemnification obligation payable under the articles of incorporation or by-laws of PSIC and PSMHC or pursuant to this Part XII with respect to acts or omissions occurring after the Plan Effective Date shall constitute administrative expense Claims of the Estates.

Part XIII Termination of this Plan and Closure of the Estate

13.01 Throughout the pendency of this Plan, the Rehabilitator shall review the condition of PSIC and PSMHC and shall report the same to the Supervising Court in the Annual Report.

13.02 If the Director determines that any provision (other than those relating to indemnification and/or exculpation) of the articles of incorporation or by-laws of either PSIC or PSMHC should be amended or changed as a condition precedent to her discharge as Rehabilitator, she may, subject to the approval of the Supervising Court, do so without further notice.

13.03 If the Rehabilitator determines that PSIC or PSMHC is no longer rehabilitatable, or that it is in the best interests of PSIC and/or PSMHC's Claimants or the public to liquidate PSIC and/or PSMHC, she shall proceed in accordance with the applicable provisions of the Code concerning the liquidation of domestic companies. If the Director files a complaint seeking the liquidation of PSIC and/or PSMHC, all payments to be made under this Plan shall terminate immediately, pending further order of the Supervising Court. If a final order of liquidation is entered against PSIC and/or PSMHC at any time, this Plan shall terminate immediately and such final order and the provisions of the Code shall prevail and be paramount to this Plan.

13.04 After the Rehabilitator has distributed all General Assets remaining under the Rehabilitator's control, the Rehabilitator shall submit a final report to the Supervising Court and may petition the Supervising Court for the dissolution of both PSIC and PSMHC, pursuant to Section 196, 215 ILCS 5/196, of the Code, and for a full discharge of all liability and responsibility of the Director as Rehabilitator and her attorneys, senior attorneys, accountants, assistants, consultants, Special Deputy and Attorney-in-Fact and their staff.

Part XIV Petitions From Stays

14.01 Claimants and other persons whose direct actions or arbitration proceedings against PSIC and/or PSMHC have been or may be stayed or dismissed as a result

of the Rehabilitation Order may assert their claims against PSIC and/or PSMHC either in the form of a petition which shall be delivered to the Rehabilitator in such manner and with such supporting documentation as the Rehabilitator shall direct, or in a manner consistent with Section 209(1), 215 ILCS 5/209(1), of the Code.

Part XV Ancillary States

15.01 This Plan does not replace or supersede any provision of Article XIII ½ of the Code, 215 ILCS 5/221.1, *et seq.*, or of any similar law enacted by any state which is a "reciprocal state" as defined in Section 221.1(1), 215 ILCS 5/221.1(1), of the Code except as specifically set forth in this Plan.

Part XVI Reservation of Rights

16.01 Nothing in the provisions of this Plan shall be construed or interpreted as a limitation or qualification of any other rights or remedies which the Director, whether acting as Rehabilitator or otherwise, may have or exercise under the Code and any amendments thereto.

16.02 Subject to the approval of the Supervising Court, and with or without notice as the Supervising Court shall order, the Rehabilitator may amend any provision of this Plan, other than Paragraph 3.03 and Part XII, at any time; provided, however, that nothing contained herein shall constitute a waiver of the rights of any party to present an objection to the Supervising Court regarding any action taken by the Rehabilitator relating to the Rehabilitation.

Part XVII Rules of Construction

17.01 The headings and captions herein are inserted for convenience of reference only, and shall not serve to limit, expand or interpret paragraphs or parts to which they apply.

17.02 Words of the masculine, feminine and neuter gender, where the context requires, shall also mean and include the correlative words of other genders. Words importing singular number, where the context requires, shall also mean and include the plural number and vice versa.

17.03 The general rule that ambiguities are to be resolved against the primary drafting party shall not apply to this Plan.

17.04 Whenever under the terms of this Plan the time for performance of a condition falls upon a Saturday, Sunday or any federal or state holiday, such time for performance shall be extended to the next business day.

17.05 Nothing in this Plan shall be construed to cause any Claimant to have any greater right than that which it would have had if this Plan had not been entered by order

of the Supervising Court.

17.06 If any provision of this Plan or the application thereof is held invalid, the invalidity shall not affect other provisions or applications of the Plan which can be given effect without the invalid provisions or applications, and to this end, the provisions of this Plan are declared to be severable.

Part XVIII Continuing Jurisdiction of Supervising Court and Choice of Law

18.01 The Supervising Court shall have continuing jurisdiction over this Plan, the distribution of General Assets, and the Rehabilitation.

18.02 All matters arising out of or relating to the construction or interpretation of Article XIII or this Plan shall be governed by the law of the state of Illinois. The Rehabilitator will apply prevailing choice-of-law principles to determine the substantive law applicable to determine issues involving the liability, coverage and value of Claims under this Plan.

18.03 All challenges of, and disputes concerning, relating to or arising under this Plan which have not been settled, compromised or adjourned between the Rehabilitator and any parties impacted by this Plan shall be presented to the Supervising Court and may not be submitted to arbitration.

18.04 In addition to any other remedies, any person who obstructs or interferes with the Director, Rehabilitator, Special Deputy, or Attorney-in-Fact in the conduct of the Rehabilitation or the implementation of this Plan shall be subject to the contempt powers of the Supervising Court.

Part XIX Finality Upon Entry of This Plan

19.01 There being no just cause to delay enforcement of or appeal from this Plan or any of the provisions contained herein, entry of this Plan by the Supervising Court shall be deemed an appealable order pursuant to Illinois Supreme Court Rule 304(b)(2), 735 ILCS 5/304(b)(2).

Respectfully submitted,

JENNIFER HAMMER, Acting Director of the Illinois Department of Insurance, acting solely in her capacity as the statutory and court-affirmed Rehabilitator of Public Service Insurance Company and Public Service Mutual Holding Company

By: _____
One of her attorneys

ENTERED:

_____
Judge Presiding

J. Kevin Baldwin
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West's Ann.Cal.Ins.Code § 1033

§ 1033. Priorities of claims; satisfaction of claims under separate account policy, contract, or agreement; administrative expenses; definitions; severability of provisions; payments to creditors

Effective: January 1, 2000
Currentness

(a) Claims allowed in a proceeding under this article shall be given preference in the following order:

(1) Expense of administration.

(2) All claims of the California Insurance Guarantee Association or the California Life and Health Insurance Guarantee Association, and associations or entities performing a similar function in other states, together with claims for refund of unearned premiums and all claims under insurance and annuity policies or contracts, including funding agreements, of an insolvent insurer that are not covered claims.

The following claims are excluded from this priority:

(A) Any obligations of the insolvent insurer arising out of any reinsurance contracts, as well as obligations incurred after the expiration date of the policy or after the insurance policy has been replaced by the insured or canceled at the insured's request, or after the policy has been canceled by the California Insurance Guarantee Association, the California Life and Health Insurance Guarantee Association, or another association or entity performing a similar function in another state.

(B) Any obligations to insurers, insurance pools, or underwriting associations, and their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

(C) Any amount awarded as punitive or exemplary damages, and any damages in excess of the liability limits of the policies or contracts that represent damages for contractual bad faith.

(D) Any amount that is a surplus deposit of a subscriber as defined in Section 1374.1.

(E) Any judgments against or obligations or liabilities of the insolvent insurer otherwise arising from alleged or proven torts, and any default, collusive, or stipulated judgment against either the insured or the person subject to proceedings under this article, as well as any judgment taken in violation of Section 1020. Nothing in this subparagraph shall prohibit the commissioner from considering the underlying claims as a claim entitled to priority under this section, provided that

the claimant shall provide to the commissioner a written election that the judgment shall in all things be disregarded in determining the liability for and valuation of the underlying claim.

(F) Any loss adjustment expenses, including adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, bond premiums, expert witness fees, and other claims of a similar nature incurred prior to the appointment of a liquidator.

(G) Claims arising from any self-insured program of the insurer, including employee life, health and annuity plans, and self-funded employee benefit plans, however denominated, as well as claims arising from a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended, a minimum premium group insurance plan, a stop-loss group insurance plan, or an administrative services-only plan.

(H) Any portion of a policy or contract to the extent that it provides experience rating credits or refunds, dividends, or for the payment of fees or allowances to any person, including the policyholder or contractholder, in connection with the service to or administration of the policy or contract.

(I) Any annuity issued by a charitable organization for which the person subject to these proceedings did not have or utilize a certificate of authority to issue the policy or contract.

(3) Claims having preference by the laws of the United States.

(4) Unpaid charges due under the provisions of Section 736.

(5) Taxes due to the State of California.

(6) Claims having preference by the laws of this state.

(7) Claims of creditors not included in paragraphs (1) to (6), inclusive.

(8) Certificates of contribution, surplus notes, or similar obligations, and premium refunds on assessable policies.

(9) The interests of shareholders or other owners in any residual value in the estate.

(b)(1) Every claim allowed under a separate account policy, contract, or agreement providing, in effect, that the assets allocated to the separate account are not chargeable with liabilities arising out of any other business of the insurer, shall be satisfied out of the assets properly allocated to and maintained in the separate account, excluding amounts allocated or transferred to the separate account by the insurer pursuant to subdivision (b) of Section 10506, equal to the reserves maintained in the separate account for the policies, contracts, or agreements. No liabilities of the insurer arising out of any other business of the insurer shall be satisfied from assets properly allocated to and maintained in a separate account except (A) from amounts allocated or transferred to the separate account pursuant to subdivision (b)

of Section 10506 and (B) from any assets allocated to the separate account that exceed the reserves under the separate account policies, contracts, or agreements. For the purposes of this subdivision, "separate account policies, contracts, or agreements" means any policies, contracts, or agreements that provide for separate accounts as contemplated by Section 10506, 10506.3, 10506.4, or 10541. Any valid and allowed claim for contractual benefits that cannot be satisfied out of the assets properly allocated to and maintained in a separate account for obligations authorized by subdivision (a) of Section 10506.3 shall be included as a claim against the general account within paragraph (2) of subdivision (a). Any valid and allowed claim against the general account for contractual benefits under an obligation authorized by Section 10506.4 shall be included as a claim within paragraph (2) of subdivision (a).

(2) Notwithstanding any other provision of law, to the extent that any assets of a life insurer, other than those assets properly allocated to, and maintained in, a separate account, have been used to fund or pay any expenses, taxes, or policyholder benefits that are attributable to a separate account policy, contract, or agreement that should have been paid by a separate account prior to the commencement of delinquency proceedings, then upon the commencement of delinquency proceedings, the separate accounts that benefited from this payment or funding shall first be used to repay or reimburse the company's general assets or account for any unreimbursed net sums due at the commencement of delinquency proceedings prior to the application of the separate account assets to the satisfaction of liabilities of the corresponding separate account policies, contracts, and agreements.

(c) Upon the issuance of an order appointing a conservator or liquidator for any person under either Section 1011 or 1016 or both these sections, the lien of taxes due to the State of California imposed by Article 4 (commencing with Section 12491) of Chapter 4 of Part 7 of Division 2 of the Revenue and Taxation Code shall become subordinate to the reasonable administrative expenses of the proceeding under the order.

(d) The following definitions are for purposes of this section only and shall not be used to determine coverage under the California Life and Health Insurance Guarantee Association Act (Article 14.7 (commencing with Section 1067)):

(1) "Funding agreements" means those agreements authorized to be delivered or issued pursuant to Section 10541.

(2) "Annuity" means only those annuity contracts, including period-certain annuities issued by a life insurer, that require for their lawful issuance a certificate of authority from the commissioner, and excludes without limitation all instruments for which the commissioner's certificate of authority is not required, such as promissory notes, installment loans, negotiable instruments, mortgages, and debentures.

(3) Reinsurance contracts shall not be included as insurance or annuity policies or contracts, or funding agreements. However, any insurance or annuity policy or contract, including any funding agreement, that is assumed by an insurer under an assumption reinsurance agreement pursuant to a plan of liquidation, rehabilitation, or reorganization shall, unless the plan provided otherwise, be deemed to retain the issue date of the original insurance or annuity policy or contract, or funding agreement that is assumed.

(e) The provisions of this section are severable. If any portion of this section is held invalid or is preempted by federal law, the remainder of the section and its application shall not be affected. Specifically, should any of paragraphs (1) to (6), inclusive, of subdivision (a) be held to be invalid or preempted by federal law, the claims included within the invalid paragraph shall be included within paragraph (7) of subdivision (a), and the remaining paragraphs shall not be affected thereby.

(f) No payment shall be made to any creditor in paragraphs (8) or (9) of subdivision (a), unless all claims in paragraphs (3) to (7), inclusive, of subdivision (a) have been paid in full, together with interest at the legal rate of the date of the order commencing the proceeding or the date on which the claim became liquidated, whichever date is later. In proceedings involving life insurance companies, no payment shall be made for any claim in paragraph (7), (8), or (9) of subdivision (a) unless and until all claims in paragraph (1) of subdivision (a) have been paid in full, together with interest at the legal rate, all claims in paragraph (2) of subdivision (a) have been paid the full value of the policy or contract upon which the claim is based, as of the time of distribution to claimants, and all claims in paragraphs (3) to (6), inclusive, of subdivision (a) have been paid in full, together with interest at the legal rate from the date of the order commencing the proceeding. Notwithstanding the provisions of this subdivision, no payment of interest shall be made to any insurance guaranty association that receives early access disbursements from the estate pursuant to Section 1035.5.

Credits

(Stats.1935, c. 145. Amended by Stats.1935, c. 291, p. 1008; Stats.1937, c. 932, p. 2564, § 4; Stats.1939, c. 934, p. 2632, § 3; Stats.1957, c. 386, p. 1222, § 3; Stats.1970, c. 1205, p. 2116, § 1.5; Stats.1972, c. 1217, p. 2353, § 1, eff. Dec. 11, 1972; Stats.1979, c. 384, p. 1445, § 1; Stats.1981, c. 714, p. 2695, § 263; Stats.1991, c. 1105 (S.B.369), § 3, eff. Oct. 14, 1991; Stats.1992, c. 427 (A.B.3355), § 112; Stats.1992, c. 956 (S.B.1490), § 3; Stats.1993, c. 974 (S.B.482), § 1.3; Stats.1994, c. 1076 (S.B.1001), § 1; Stats.1995, c. 795 (S.B.1328), § 2; Stats.1996, c. 167 (S.B.1705), § 4; Stats.1997, c. 497 (S.B.1277), § 1; Stats.1999, c. 868 (S.B.374), § 1.)

Notes of Decisions (13)

West's Ann. Cal. Ins. Code § 1033, CA INS § 1033
Current with urgency legislation through Ch. 1016 of 2018 Reg.Sess, and all propositions on 2018 ballot.

End of Document

V.T.C.A., Insurance Code § 443.301

§ 443.301. Priority of Distribution

Effective: September 1, 2015
Currentness

The priority of payment of distributions on unsecured claims must be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full, or adequate funds retained for their payment, before the members of the next class receive payment, and all claims within a class must be paid substantially the same percentage of the amount of the claim. Except as provided by Subsections (a)(2), (a)(3), (i), and (k), subclasses may not be established within a class. No claim by a shareholder, policyholder, or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution of claims shall be:

(a) Class 1. (1) The costs and expenses of administration expressly approved or ratified by the liquidator, including the following:

(A) the actual and necessary costs of preserving or recovering the property of the insurer;

(B) reasonable compensation for all services rendered on behalf of the administrative supervisor or receiver;

(C) any necessary filing fees;

(D) the fees and mileage payable to witnesses;

(E) unsecured loans obtained by the receiver; and

(F) expenses, if any, approved by the rehabilitator of the insurer and incurred in the course of the rehabilitation that are unpaid at the time of the entry of the order of liquidation.

(2) The reasonable expenses of a guaranty association, including overhead, salaries and other general administrative expenses allocable to the receivership to include administrative and claims handling expenses and expenses in connection with arrangements for ongoing coverage, other than expenses incurred in the performance of duties under Section 462.002(3), 463.108, 463.111, 463.113, 463.353, or 2602.113 or similar duties under the statute governing a similar organization in another state. In the case of the Texas Property and Casualty Insurance Guaranty Association

and other property and casualty guaranty associations, the expenses shall include loss adjustment expenses, including adjusting and other expenses and defense and cost containment expenses. In the event that there are insufficient assets to pay all of the costs and expenses of administration under Subsection (a)(1) and the expenses of a guaranty association, the costs and expenses under Subsection (a)(1) shall have priority over the expenses of a guaranty association. In this event, the expenses of a guaranty association shall be paid on a pro rata basis after the payment of costs and expenses under Subsection (a)(1) in full.

(3) For purposes of Subsection (a)(1)(E), any unsecured loan obtained by the receiver, unless by its terms it otherwise provides, has priority over all other costs of administration. Absent agreement to the contrary, all claims in this subclass share pro rata.

(4) Except as expressly approved by the receiver, any expenses arising from a duty to indemnify the directors, officers, or employees of the insurer are excluded from this class and, if allowed, are Class 5 claims.

(b) Class 2. (1) All claims under policies of insurance, including third-party claims; claims under annuity contracts, including funding agreements, guaranteed investment contracts, and synthetic guaranteed investment contracts; claims under nonassessable policies for unearned premium; claims of obligees and, subject to the discretion of the receiver, completion contractors, under surety bonds and surety undertakings other than bail bonds, mortgage or financial guaranties, or other forms of insurance offering protection against investment risk; claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents; and claims incurred during the extension of coverage provided for in Section 443.152. For purposes of this subdivision, “annuity contract,” “funding agreement,” “guaranteed investment contract,” and “synthetic guaranteed investment contract” have the meanings assigned by Section 1154.003.

(2) All other claims incurred in fulfilling the statutory obligations of a guaranty association not included in Class 1, including indemnity payments on covered claims and, in the case of the Life, Accident, Health, and Hospital Service Insurance Guaranty Association or another life and health guaranty association, all claims as a creditor of the impaired or insolvent insurer for all payments of and liabilities incurred on behalf of covered claims or covered obligations of the insurer and for the funds needed to reinsure those obligations with a solvent insurer.

(3) Claims for benefits under a health care plan issued by a health maintenance organization.

(4) Claims under insurance policies or contracts for benefits issued by an unauthorized insurer.

(5) Notwithstanding any provision of this chapter, the following claims are excluded from Class 2 priority:

(A) obligations of the insolvent insurer arising out of reinsurance contracts;

(B) obligations, excluding unearned premium claims on policies other than reinsurance agreements, incurred after:

(i) the expiration date of the insurance policy;

(ii) the policy has been replaced by the insured or canceled at the insured's request; or

(iii) the policy has been canceled as provided by this chapter;

(C) obligations to insurers, insurance pools, or underwriting associations and their claims for contribution, indemnity, or subrogation, equitable or otherwise;

(D) any claim that is in excess of any applicable limits provided in the insurance policy issued by the insurer;

(E) any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy;

(F) tort claims of any kind against the insurer and claims against the insurer for bad faith or wrongful settlement practices; and

(G) claims of the guaranty associations for assessments not paid by the insurer, which must be paid as claims in Class 5.

(c) Class 3. Claims of the federal government not included in Class 2.

(d) Class 4. Debts due employees for services or benefits to the extent that the debts do not exceed $5,000 or two months salary, whichever is the lesser, and represent payment for services performed within one year before the entry of the initial order of receivership. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(e) Class 5. Claims of other unsecured creditors not included in Classes 1 through 4, including claims under reinsurance contracts, claims of guaranty associations for assessments not paid by the insurer, and other claims excluded from Class 2.

(f) Class 6. Claims of any state or local governments, except those specifically classified elsewhere in this section. Claims of attorneys for fees and expenses owed them by an insurer for services rendered in opposing a formal delinquency proceeding. In order to prove the claim, the claimant must show that the insurer that is the subject of the delinquency proceeding incurred the fees and expenses based on its best knowledge, information, and belief, formed after reasonable inquiry, indicating opposition was in the best interests of the insurer, was well grounded in fact, and was warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that opposition was not pursued for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of the litigation.

(g) Class 7. Claims of any state or local government for a penalty or forfeiture, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The balance of the claims must be treated as Class 9 claims under Subsection (i).

(h) Class 8. Except as provided in Sections 443.251(b) and (d), late filed claims that would otherwise be classified in Classes 2 through 7.

(i) Class 9. Surplus notes, capital notes or contribution notes or similar obligations, premium refunds on assessable policies, and any other claims specifically assigned to this class. Claims in this class are subject to any subordination agreements related to other claims in this class that existed before the entry of the liquidation order.

(j) Class 10. Interest on allowed claims of Classes 1 through 9, according to the terms of a plan proposed by the liquidator and approved by the receivership court.

(k) Class 11. Claims of shareholders or other owners arising out of their capacity as shareholders or other owners, or any other capacity, except as they may be qualified in Class 2, 5, or 10. Claims in this class are subject to any subordination agreements related to other claims in this class that existed before the entry of the liquidation order.

Credits

Added by Acts 2005, 79th Leg., ch. 995, § 1, eff. Sept. 1, 2005. Redesignated from V.A.T.S. Insurance Code, art. 21A.301 by Acts 2007, 80th Leg., ch. 730, § 3B.004(a)(1)(G), eff. Sept. 1, 2007; Acts 2007, 80th Leg., ch. 921, § 9.004(a)(1)(G), eff. Sept. 1, 2007. Amended by Acts 2007, 80th Leg., ch. 730, § 3B.004(jj), eff. Sept. 1, 2007; Acts 2007, 80th Leg., ch. 921, § 9.004(jj), eff. Sept. 1, 2007; Acts 2011, 82nd Leg., ch. 193 (S.B. 1433), § 10, eff. Sept. 1, 2011; Acts 2015, 84th Leg., ch. 1187 (S.B. 1196), § 1, eff. Sept. 1, 2015.

V. T. C. A., Insurance Code § 443.301, TX INS § 443.301
Current through the end of the 2017 Regular and First Called Sessions of the 85th Legislature

End of Document

McKinney's Consolidated Laws of New York Annotated
Insurance Law (Refs & Annos)
Chapter 28. Of the Consolidated Laws (Refs & Annos)
Article 76. Property/Casualty Security Funds (Refs & Annos)

McKinney's Insurance Law § 7602

§ 7602. Definitions

Effective: July 31, 2013
Currentness

In this article, unless the context or subject matter otherwise requires:

(a) "Fund" means either the property/casualty insurance security fund or the public motor vehicle liability security fund.

(b) "Fund year" means the calendar year.

(c) "Insurer" means any insurer (other than an insolvent insurer, or a municipal reciprocal insurer which issues policies not covered by the property/casualty insurance security fund, or a risk retention group as defined in article fifty-nine of this chapter, or a provider of service contracts pursuant to article seventy-nine of this chapter) authorized to transact the kinds of business specified in paragraphs four through fourteen, sixteen, seventeen, nineteen through twenty-one of subsection (a) of section one thousand one hundred thirteen of this chapter.

(d) "Policy" means a policy issued by an insurer authorized to do business in this state, including a policy or surety bond filed pursuant to article six or seven of the vehicle and traffic law, insuring against legal liability arising out of the ownership, operation or maintenance of motor vehicles, including surety bonds or insurance policies issued to meet the requirements of section three hundred seventy of the vehicle and traffic law.

(e) "Net direct written premiums" means direct gross premiums written on policies subject to this article, insuring:

(1) property or risks located or resident in this state,

(2) legal liability arising out of the ownership, operation or maintenance of motor vehicles which are principally garaged in this state, less return premiums thereon and dividends paid to policyholders on such direct business.

For the purposes of this article premiums written by any authorized insurer on policies issued to self insurers, whether or not designated as reinsurance contracts, shall be deemed "net direct written premiums".

(f) "Motor vehicle accident" means either an accident occurring within or without this state arising out of the ownership, operation or maintenance of a motor vehicle which is principally garaged in this state or an accident occurring within

this state arising out of the ownership, operation or maintenance of a motor vehicle which is not principally garaged in this state.

(g) "Allowed claim" means a claim that has been allowed by the superintendent in a proceeding under article seventy-four of this chapter or, if such claim exceeds twenty-five thousand dollars, has been allowed by the court in a proceeding under article seventy-four of this chapter, and which is based upon:

(1) a policy insuring property or risks located or resident in this state, or

(2) a policy issued in this state to a resident of this state insuring property or risks, located or resident outside this state but within the United States, its possessions and territories, and Canada, provided that, with respect to policies covered under this paragraph:

(A) irrespective of the amount of claim that has been allowed, no person shall recover any amount from this fund until such person has exhausted all rights of recovery from any security fund, guaranty association, or the equivalent in the jurisdiction where such property or risks are located or resident; and, thereafter, such person's recovery from this fund, when combined with amounts recovered or recoverable from any other security fund, guaranty association, or the equivalent in such jurisdiction, shall not exceed the maximum limit available to a qualified claimant for a recovery solely from such other security fund, guaranty association, or the equivalent; and

(B) the aggregate limit for all claims arising out of any one policy, excluding claims with respect to property or risks located or resident in this state, shall not exceed the lesser of the aggregate limit of the policy or five million dollars.

(h) "Injured party claim" means a claim of a person, other than a policyholder or assured, who suffered an injury to his person or property arising out of an insured incident within the coverage of the policy.

(i) "Policyholder claim" means a claim of a policyholder or assured within the coverage of the policy, wherein such person suffered loss or damage under the coverage of the policy or where such person has paid an injured party claim, subject to allowance of such policyholder claim in a proceeding under article seventy-four of this chapter.

(j) "Commissioner" means the commissioner of taxation and finance of this state.

Credits

(L.1984, c. 367, § 1. Amended L.1986, c. 220, § 27; L.1988, c. 109, § 8; L.1990, c. 578, § 1; L.1997, c. 614, § 14, eff. Jan. 15, 1998; L.2013, c. 238, § 21, eff. July 31, 2013.)

Notes of Decisions (8)

McKinney's Insurance Law § 7602, NY INS § 7602
Current through L.2018, chapters 1 to 321.

End of Document

McKinney's Consolidated Laws of New York Annotated
Insurance Law (Refs & Annos)
Chapter 28. Of the Consolidated Laws (Refs & Annos)
Article 76. Property/Casualty Security Funds (Refs & Annos)

McKinney's Insurance Law § 7603

§ 7603. Property/casualty insurance security fund

Effective: October 2, 2002
Currentness

(a)(1) The property/casualty insurance security fund shall be used in the payment of allowed claims remaining unpaid, in whole or in part, by reason of the inability due to insolvency of an authorized insurer to meet its insurance obligations under policies:

(A) on account of claims from motor vehicle accidents as defined in subsection (f) of section seven thousand six hundred two of this article,

(B) for all of the kinds of insurance specified in paragraphs four through fourteen, sixteen, nineteen through twenty-one, twenty-four and subparagraphs (A) and (B) of paragraph twenty-six of subsection (a) of section one thousand one hundred thirteen of this chapter with respect to coverage of property or risks located or resident in this state, or outside this state but within the United States, its possessions and territories, and Canada,

(C) for the kind of insurance providing disability benefits pursuant to article nine of the workers' compensation law issued by an authorized insurer licensed under article forty-one, sixty-one or sixty-six of this chapter with respect to coverage of risks located or resident in this state,

(D) in the kind of insurance providing workers' compensation insurance pursuant to subsection (j) of section three thousand four hundred twenty of this chapter,

(E) for the insurance provided by the medical malpractice insurance association,

(F) for the insurance provided pursuant to subdivision two-a of section seventy-six of the workers' compensation law if and when operative,

(G) for the kinds of credit insurance as defined in subparagraphs (B) and (C) of paragraph seventeen of subsection (a) of section one thousand one hundred thirteen of this chapter, and

(H) any obligation for the return of unearned premiums on any policy specified in subparagraphs (A), (B), (C), (D), (E), (F) and (G) hereof, which shall, for the purposes of this article, be deemed to include the obligations of an insurer and the medical malpractice insurance association under medical malpractice claims-made policies to pay to successor entities

the actuarially appropriate amounts for the provision of coverage to comply with the requirements of subsections (b), (c) and (d) of section three thousand four hundred thirty-six and paragraphs two, three and four of subsection (f) of section five thousand five hundred four of this chapter.

(2) No payment from the property/casualty insurance security fund shall be made to any person who owns or controls ten percent or more of the voting securities of the insolvent insurer and no payment on any one claim shall exceed one million dollars, provided that the amount of payment on a claim and the aggregate for all claims shall be further limited by the provisions of paragraph two of subsection (g) of section seven thousand six hundred two of this article.

(b)(1) Contributions to the property/casualty insurance security fund shall be determined on the basis of net direct written premiums on policies insuring property or risks located or resident in this state.

(2) Every insurer shall pay into such fund, upon filing each quarterly return pursuant to section seven thousand six hundred five of this article, one-half of one percent of its net direct written premiums as shown for the period covered by such return.

(c)(1) Whenever the superintendent determines, pursuant to section seven thousand six hundred six of this article, that the net value of the property/casualty insurance security fund is at least one hundred fifty million dollars, no further contributions shall be made after the fund year in which the determination is first made, but if thereafter the superintendent determines that payments made from the fund by the commissioner to the superintendent acting as liquidator, rehabilitator or conservator have reduced the net value to an amount less than such amount, the superintendent shall cause contributions to be resumed until the end of the fund year in which he first determines that such net value exceeds such amount.

(2) If contributions are so resumed, they shall be apportioned:

(A) ratably among those kinds of insurance as to which the commissioner made payments during the fund year in which the net value of the property/casualty insurance security fund was reduced below such amount, and

(B) among insurers in accordance with their respective amounts of net direct premiums written in each such kind of insurance.

(d)(1) All income earned on moneys in the fund (after deducting any amounts paid for allowed claims and administrative expenses during the preceding year) shall be credited, upon certification by the superintendent to the commissioner, to the general fund of the state treasury; except that with respect to all such income earned on or after July first, nineteen hundred seventy-nine such moneys shall be distributed annually in the following manner:

(A) Pursuant to regulations of the superintendent, the deficit from the operations of the New York property insurance underwriting association shall be credited with such income earned, upon certification by the superintendent to the commissioner, in a sum not exceeding such total income earned or the sum of fifteen million dollars whichever is the lesser in any one year. Such credit shall be in lieu of a transfer of such funds to the general fund of the state treasury.

(B) Any balance of earned income shall be credited, upon certification by the superintendent to the commissioner, to the general fund of the state treasury; but only when the value of the fund exceeds the sum of two hundred forty million dollars.

(2) The superintendent, after consultation with the commissioner, may by regulation provide for contributions to be made in the form of acceptable securities, and for the management and disposition of such securities. The income from such securities shall be included in the distribution outlined in paragraph one hereof.

(3) The superintendent is authorized to use the income earned on the moneys of the fund to offset the deficit of the New York property insurance underwriting association in accordance with subsection (d) of section five thousand four hundred five of this chapter, provided that any income earned on the moneys of the fund which in any one year exceeds fifteen million dollars or which the superintendent has not utilized for the purposes of such subsection shall be credited to the corpus of the fund until the superintendent determines that its net value is two hundred forty million dollars, and thereafter shall be credited, upon certification by the superintendent to the commissioner, to the general fund of the state treasury.

(e)(1)(A) Notwithstanding any other provision of law to the contrary, the superintendent shall annually no later than November first in each year submit to the director of the budget a request for an appropriation of ninety million dollars. The governor shall include such amount in a budget bill for the next state fiscal year. The state comptroller shall encumber the amount so appropriated before the end of the fiscal year for which any such appropriation is made. If for any fiscal year commencing on or after April first, nineteen hundred eighty-three, the governor fails to submit a budget bill containing an appropriation in the amount requested by the superintendent or the legislature fails to appropriate the amount in a budget bill submitted by the governor for such fiscal year, the amount appropriated for and encumbered during the preceding fiscal year shall be payable forthwith to the fund on July first of such year in the manner prescribed by law, provided, however, that such amount shall not exceed the amount of moneys transferred to the general fund from the fund pursuant to the provisions of chapter fifty-five of the laws of nineteen hundred eighty-two.

(B) Any appropriation made to the fund pursuant to this section shall be included as an asset for the purposes of computing the value or net value of the fund pursuant to this section.

(C) Any transfer of moneys from the fund to the general fund in accordance with the provisions of chapter fifty-five of the laws of nineteen hundred eighty-two is deemed a proper and prudent legal undertaking for any state officer with the responsibility for the custody or the investment of the assets of the fund, notwithstanding any other provision of law to the contrary.

(2) Upon certification by the superintendent that further sums, not exceeding fifty million dollars in the aggregate, are required by the public motor vehicle liability security fund to meet its obligations and accomplish the purposes of this article the commissioner shall transfer from the assets of the property/casualty insurance security fund to the public motor vehicle liability security fund amounts to be specified by the superintendent. Such sums, not exceeding fifty million dollars in the aggregate, shall be a liability of the public motor vehicle liability security fund and shall be repaid to the property/casualty insurance security fund pursuant to a plan of repayment to be prescribed by the superintendent which may provide for an increase in the level of payments into the fund provided for in subsection (b) of section seven thousand six hundred four of this article.

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Excalibur Reinsurance Corporation, In Liquidation	:	No. 1 ERC 2016

LIQUIDATOR'S APPLICATION TO ESTABLISH A CLAIMS BAR DATE

Jessica K. Altman, Acting Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Liquidator ("Liquidator") of Excalibur Reinsurance Corporation (In Liquidation) ("Excalibur"), by her undersigned counsel, respectfully applies to this Court to establish a claims bar date ("Bar Date"). In support of this Application, the Liquidator offers the following:

Background

1. Excalibur was placed in liquidation by Order of this Court on July 18, 2016 ("the Liquidation Order").

2. The Liquidation Order provided that in addition to the notice requirements of Section 524 of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended*, added by the Act of December 14, 1977, P.L. 280, 40 P.S. §§ 221.1- 221.63 ("Act"), the Liquidator should publish notice to provide information about the procedures for filing claims, and to file a report demonstrating the date and manner notice was given within 30 days of giving notice of the Liquidation Order and the claims filing procedures.

3. Pursuant to the Liquidation Order, the Liquidator noticed creditors and potential creditors or claimants of Excalibur, published notice, and filed a report with this Court on October 3, 2016, demonstrating the date and manner notice was given. The Liquidator is also simultaneously filing with this Application a report that supplements the aforementioned October 3, 2016 report.

4. Section 537(a) of the Act mandates that proof of all claims shall be filed with the Liquidator in the form required by Section 538 of the Act on or before the last day for filing specified in the above-referenced notice required under Section 524 of the Act.

5. Pursuant to Section 538 of the Act, a proof of claim shall consist of a statement signed by the claimant that includes all of the following elements that are applicable: (a) the particulars of the claim including the consideration given for it; (b) the identity and amount of the security on the claim; (c) the payments made on the debt, if any; (d) that the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim; (e) any right of priority of payment or other specific right asserted by the claimants; (f) a copy of written instrument which is the foundation of the claim; (g) in the case of any third party claim based on a liability policy issued by the insurer, a conditional release of the insured pursuant to Section 540(a) of the Act; and (h) the name and address of the claimant and the attorney who represents him, if any. Furthermore, the Liquidator may require that other information and documents be included in addition to the above-referenced requirements.

6. A proof of claim that meets all of the applicable requirements set forth in Section 538, including any other information required by the Liquidator, and is filed by the last day for filing specified in the notice required under Section 524 of the Act, is considered a timely filed

absolute claim that is ripe for the issuance of a Notice of Determination ("NOD" or "NODs" for multiple notices of determination) by the Liquidator.

7. A proof of claim that meets all of the applicable requirements set forth in Section 538, including any other information required by the Liquidator, but is not filed by the last day for filing specified in the notice required under Section 524, is considered a late-filed absolute claim, and is ripe for the issuance of a NOD by the Liquidator. For good cause shown, late filed claims may share in distributions as if the claim was not late, to the extent such payment will not prejudice the orderly administration of the liquidation, in accordance with Section 537(b) of the Act.

8. Regardless of whether the proof of claim is filed before or after the claims filing deadline, Section 538(a) of the Act specifically provides that "[N]o claim need be considered or allowed if it does not contain all the foregoing information which may be applicable".

9. The Liquidator may, however, consider and allow claims that are filed with the Liquidator that have not become absolute because of the existence of a contingency which must occur in order for the claim to become absolute.

10. If a claim is contingent and becomes absolute before the claims filing deadline, including the provision of any other information required by the Liquidator, a NOD is issued.

11. If a claim is contingent and becomes absolute after the claims filing deadline and the claimant files its proof of claim setting forth all the requirements of Section 538 as soon as reasonably possible after it became absolute, the Liquidator for good cause under Section 537(b) may permit the claimant to share in the distributions as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation. Whether or not good cause is shown to excuse the late filed contingent claim, the Liquidator will issue a NOD when the contingent claim becomes absolute.

12. For purposes of this Application, the Liquidator sets forth the following defined terms. Definitions may include defined terms. Defined terms are capitalized.

> **POC** — A "POC" is a proof of claim form distributed by the Liquidator in connection with the liquidation of Excalibur. Multiple proofs of claim are designated as "POCs".
>
> **CONTINGENT CLAIM** — A "Contingent Claim" is a claim involving a demand that is based on a legal cause of action or an instituted legal action that is reported to the Liquidator prior to the Bar Date under a POC that includes one or more of the following features: (a) demands that are not capable of becoming absolute by the Bar Date due to contingent matters that extend beyond the Bar Date; and/or (b) an instituted legal action where the liability has not been determined or the amount thereof liquidated by the Bar Date, and thus these claims are not absolute as required by Section 538.
>
> **ABSOLUTE** — "Absolute" means that claimants have provided to the Liquidator sufficient information and documentation describing the facts of the claim, including but not limited to: (a) a detailed statement describing the claim; (b) a detailed statement describing the dollar value of the claim; (c) documents evidencing damage; and (d) all other information or documents helpful to proving the claim, including any other information required by the Liquidator, all as required by Section 538 of the Act and the instructions on the POC form. When the POC is absolute, a NOD is issued.

Status of the Claims in the Excalibur Estate

13. Between July 18, 2016 and October 31, 2017, the Liquidator has received 187 completed POCs. The following graph details when those POCs have been received, and demonstrates that the volume of POCs received has greatly diminished over the last 11 months since the claims filing deadline of November 30, 2016.

	Received by		Claims Filing Deadline				
	9/30/2016	10/31/2016	11/30/2016	1/31/2017	3/31/2017	6/30/2017	10/31/2017
	10	20	143	2	9	2	1
	10	30	173	175	184	186	187

14. The Liquidator has issued NODs for 92 of the 187 POCs that have been received. Eighty five (85) of the NODs have been accepted. The other 7 POCs where NODs have been issued are all pending with the claimant. Of the other 95 remaining POCs that have not yet been issued a NOD, all are Contingent Claims.

Claims Arising From Assumed Reinsurance

15. Excalibur was primarily in the reinsurance business. As a reinsurer, its customers were large, sophisticated insurance companies. Being regulated entities themselves, this group of creditors understand the insurance company liquidation process, including the importance of filing a timely POC, such that it is unlikely that any such creditors with claims have not yet filed a POC.

16. The largest number of claims filed against Excalibur are claims to recover reinsurance, many of which involve on-going payments for an indefinite period or involve complex and extensive underlying litigation and/or settlement processes, and which are general creditor claims under Section 544 of the Act and applicable case law. (See Alabama Ins. Guar. Assoc. v. Reliance Ins. Co. in Liquidation, 100 A.3d 702 (Pa. Commw. 2014), aff'd. *per curiam*, 121 A.3d 954 (Pa. 2015); CSAC Excess Ins. Auth. v. Reliance Ins. Co., No. 1 REL 2007 (Pa. Commw. Nov. 8, 2012), aff'd. 78 A.3d 1058 (Pa. 2013); Consedine v. Reliance Ins. Co., 35 A.3d

1232, 1240 (Pa. Commw. 2011); Koken v. Reliance Ins. Co., No. 269 N.D. 2001, Slip Op. at 4-5 (Pa. Commw. Dec. 8, 2005)). If the estate were to be kept open awaiting resolution of these general creditor claims, the estate's asset base would be eroded by the ongoing costs of administration to the detriment of the estate's creditors.

17. In addition to assumed reinsurance, Excalibur wrote a very small amount of direct policies in its own name. There are only two open claims of this type, which are workers compensation claims being handled by the Alabama Guaranty Fund.

18. Excalibur also has potential liability related to certain policies issued by a former subsidiary. The potential liability arises in one of two ways. In cases where the policyholder's signature on a certificate of assumption constitutes a valid novation, Excalibur's potential liability arises under its capacity as the insurer assuming the obligations from its former subsidiary under these policies. In cases where the policyholder did not sign the certificate of assumption, or otherwise acknowledge acceptance of the assumption, Excalibur's potential liability arises under parental guaranty endorsements attached to the policies.

19. The potential liability that may arise under these policies is from latent injury claims or latent defect claims. The most common latent injury claims ordinarily would be asbestos claims, but these policies excluded asbestos related claims. Regardless, latent injury claims are long-tail in nature meaning that any potential liability may not, if at all, develop into a claim until many years into the future. There is also a small group of potential claims related to latent defects within the completed work of construction trade contractors. In these instances, a trade contractor has performed work that is subject to prospective failure after the general contractor or developer has made final payment. The defect lays dormant and hidden for a period of time, and can lead to

belated claims against the trade contractor. The timing of any long-tail claim is not predictable and they may not be discovered for years. However, as statute of limitations periods have passed, it is only where a statute may have been tolled that future liability may exist.

20. Finally, and importantly, prior to liquidation, Excalibur was engaged in a run-off plan for over 10 years that substantially wound down its liabilities through commutations negotiated with its ceding company clients, thus limiting the potential pool of claimants in the liquidation. As a result, at the date of the Liquidation Order, there were no policies in force, with the last policy having expired on March 1, 2005.

21. In summary, because of the type of business Excalibur wrote, the lengthy period of run-off preceding liquidation, the small size of the company's liabilities at the date of liquidation, and the significant decrease in the number of claims that have been filed in recent months, as seen in paragraph 13, it is reasonable to conclude that the vast majority of the Excalibur estate's claims have already been filed. Accordingly, it is reasonable to expect that the number of claims that may be filed prospectively will be very limited.

Reasons for Seeking a Bar Date

22. Although the Excalibur estate has only been open for approximately 16 months, the Liquidator has determined that it is time to seek the Court's approval of a final date after which no POCs will be permitted (i.e., the Bar Date). Some of the reasons for the Liquidator's determination are unique to a reinsurance company such as Excalibur, as detailed in paragraphs 15 through 21 above. There are additional reasons as well, which include the following.

23. Notwithstanding the conclusion and expectation mentioned in paragraph 21, unless a Bar Date is established, the Liquidator cannot know, with absolute certainty, at what point

in time all POCs have been filed, since conceivably, they could be submitted for several years to come. This could result in the Excalibur liquidation remaining open indefinitely until all new claims are determined and all litigation is resolved. Moreover, the Liquidator would be unable to calculate the amount of any final pro-rata distribution until the value of all claims was determined.

24. If untimely filed claims, including contingent claims, were to be considered and allowed after the Bar Date, it would adversely impact the distribution percentage to be received by claimants who have legitimate, timely filed claims that will receive a distribution from the Excalibur estate. Furthermore, the longer the estate remains open, the more administrative expenses are incurred, which further decreases the distribution percentage to be received by those claimants waiting for a distribution from the estate. This consideration is of particular note and concern in the Excalibur estate, which is a very small estate with very limited assets.

25. The only potential claimants who would not file an absolute proof of claim by the Bar Date, or who will be unable to submit documents supporting their claims by the Bar Date, will be potential claimants who cannot meet the requirements in Section 538 of the Act for filing an absolute claim. It is inequitable to delay for a significant period the distribution to the vast majority of creditors for the benefit of a small number of "potential" future creditors, who may or may not have claims develop after the Bar Date.

26. For these reasons, the order establishing a Bar Date ("the Bar Date Order") should, with respect to claims to which the Bar Date applies, preclude the filing of claims after the Bar Date for any reason, including, without limitation, a reason constituting "good cause" under Section 537 of the Act, including but not limited to contingent POCs.

27. If a POC filed before the Bar Date asserts a claim that does not involve a demand that is based on a legal cause of action or a claim that does not involve an instituted legal action and the claimant cannot provide the Liquidator with the requirements of Section 538 of the Act prior to the Bar Date, the Bar Date Order should disallow that POC.

28. The Bar Date should apply to all claims arising out of actions or omissions (including representations concerning reinsurance and insurance contracts) of Excalibur, its officers, employees, agents and representatives prior to liquidation or arising out of contracts (other than reinsurance and insurance contracts) entered into by Excalibur prior to liquidation. It should further apply to all claims arising out of post-liquidation actions or omissions (including representations concerning reinsurance and insurance contracts) of Excalibur, the Liquidator or their officers, employees, agents and representatives (including, but not limited to, attorneys, auditors, actuaries, accountants, consultants and other professionals, whether employees or independent contractors), or arising out of post-liquidation contracts entered into by Excalibur or the Liquidator, as long as those actions, omissions or breaches of contract occurred prior to the Bar Date. If a claim first arises within the thirty (30) days prior to the Bar Date, the filing of a POC should be allowed after the Bar Date but only within thirty (30) days of when the claim arose.

29. The Bar Date should not apply to routine administrative expense claims. However, the claims to which the Bar Date would apply include claims allegedly arising out of or based in any way on the conduct of the liquidation proceedings, and the effects of the Liquidation Order, even if such claims could possibly be characterized as administrative expense claims or policyholder claims.

30. The Bar Date would not apply to, or affect in any way, claims, actions or rights of Excalibur or the Liquidator.

31. The Bar Date Order should provide that neither the establishment of a Bar Date nor the recognition of certain exceptions to the preclusive effect of the Bar Date constitutes the waiver of any defenses to individual POCs, including any defenses otherwise based on the untimeliness of the claims.

32. The entry of the Bar Date Order should not be viewed as an occasion for a claimant to refile or reargue a claim that has previously been submitted. Accordingly, the Bar Date Order should provide that the filing of duplicate POCs is neither required nor permitted and that the Liquidator shall disallow duplicative claims without further consideration of their merits.

33. The Liquidator requests that the Court establish the Bar Date at the earliest possible time and that the Bar Date be no more than forty-five (45) days after the Order setting that date.

34. Accordingly, the Liquidator requests that the Court enter the proposed Order attached hereto, which in addition to establishing the Bar Date, also approves the form, scope and mailing of the Notice of the Bar Date Order attached to this Application as Exhibit "A", and the form of Publication Notice of the Bar Date Order attached to this Application as Exhibit "B".

35. In support of her request for a Bar Date Order, the Liquidator would note that this Court has approved eight prior requests for a Bar Date Order in other liquidation proceedings, specifically the PHICO Insurance Company liquidation, the Rockwood Insurance Company liquidation, the Westmoreland Insurance Company liquidation, the First Sealord Surety, Inc., liquidation, the Legion Insurance Company liquidation, the Villanova Insurance Company liquidation, the Commonwealth Insurance Company liquidation, and the Reliance Insurance Company liquidation.

WHEREFORE, the Liquidator respectfully requests the entry of the proposed Order in the form attached hereto establishing a Bar Date, approving the form, scope and mailing of the Notice of the Bar Date Order attached to this petition as Exhibit "A", and the Proof of Claim form that is attached to this petition as Exhibit "B".

Respectfully submitted,

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Dated: 11/22/17