

**South Carolina Department of Consumer Affairs**

PEO Continuing Education Seminar

September 27, 2007

S.C. Department of Consumer Affairs  
3600 Forest Drive  
Columbia, South Carolina

Agenda

- 9:00 - 9:15 AM      **Registration**
- 9:15 - 9:30 AM      **Welcome**  
*Brandolyn Thomas Pinkston*  
*Administrator - South Carolina Department of Consumer Affairs*
- 9:30 - 11:10 AM    **Professional Performance Practices and Profitability**  
*Milan P. Yager*  
*Executive Vice President - National Association of Professional Employer Organizations*
- 11:10 - 11:25 AM    **Break**
- 11:25 - 12:15 PM    **Professional Performance Practices and Profitability (continued)**  
*Milan P. Yager*  
*NAPEO*
- 12:15 - 1:45 PM     **Lunch** (On Your Own)
- 1:45 - 2:35 PM      **Hiring of Foreign Workers**  
**Identity Theft**  
*Tom Sheaffer*  
*Tax Specialist - Internal Revenue Service*
- 2:35 - 3:25 PM      **Large Deductibles in an Ideal World**  
*Lynn Szymoniak, Esquire*  
*The Szymoniak Firm*
- 3:25 - 3:40 PM      **Break**
- 3:40 - 4:30 PM      **Legislative Update**  
*Garry Smith*  
*S.C. Workers' Compensation Commission*





**2007**  
**South Carolina**  
**Professional Employer Organization**  
**Continuing Professional Education**  
**Seminar**

**Monday, September 27, 2007**

PROFESSIONAL PERFORMANCE PRACTICES AND  
PROFITABILITY

MILAN P. YAGER

**Milan P. Yager**  
Executive Vice President  
National Association of Professional Employer Organizations

Milan Yager is the Executive Vice President of the National Association of Professional Employer Organizations, a national trade association recognized as the voice of the professional employer organization industry. Mr. Yager is a long-time Washington lobbyist and association executive who has over 24 years of senior government and public affairs experience in the public and private sectors. His background includes senior government positions in the Administration and Congress. As a presidential appointee, he ran the policy office of the nation's oldest independent regulatory agency. As the chief of staff to then Congressman and now Senate Majority Whip Durbin, he gave direction and shape to national policy including the limitation of smoking on the nation's airlines. As a candidate for public office, he was noted for an expertise in school aid policy. In the private sector he has experience with three national trade associations and the founder of a business-consulting firm specializing in historic renovations. He is a graduate of the University of Iowa and holds a Masters of Public Administration from The American University in Washington, D.C. He lives in Alexandria, Virginia with his wife and their three boys.

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*NAPEO is the recognized voice of the professional employer organization industry. NAPEO members generate more than 75% of the industry's \$54 billion in gross revenues. Professional employer organizations (PEOs) enable clients to cost-effectively outsource the management of human resources, employee benefits, payroll and workers' compensation. PEO clients focus on their core competencies to maintain and grow their bottom line.*

**NAPEO**  
**901 N Pitt Street, Suite 150**  
**Alexandria, Virginia 22314**  
[www.napeo.org](http://www.napeo.org)



# Professional Performance Practices and Profitability

**Milan P. Yager**

Executive Vice President

**The National Association of  
Professional Employer  
Organizations**

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# Professional Performance Practices and Profitability

- **Employee Leasing and the early 1980s**
  - Address industry concerns to ensure individual success
  - Threats of survival coming from within
  - Need to define the industry

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# Professional Performance Practices and Profitability

## Texas Attorney General

“employee leasing is NOT legal in Texas”

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# Professional Performance Practices and Profitability

## First Era

- **Quick Pension Sale**
  - 1982 Passage of TEFRA
  - 1986 Section 414(n)



# Professional Performance Practices and Profitability

## Second Era

- **Volume Benefits or Easy Component Sale**
  - Self Funded Healthcare
  - Easy Workers' Comp
  - SUTA Dumping / SUTA Farming

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# Professional Performance Practices and Profitability

## Third Era

- **Selling Value**
  - **Hard Workers' Comp Market**
  - **New HR Outsourcing Industry**
  - **Surprising Client Profitability**

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# Professional Performance Practices and Profitability

## Land of the Wild West

- Boom business of late 1990s
- More than just lemonade
- Country without boundaries
  - Particulars are undifferentiated

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# Professional Performance Practices and Profitability

## *Consumer and Regulatory Demands*

- **Voluntary Compliance**
- **Best Professional Practices**
- **Clarity of Legal Basis**
- **Legal Certainty**

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# Professional Performance Practices and Profitability

## Outsourcing

- Difference is the employment relationship
  - Two Common Law Employers
    - Vizcaino v. District Court*
- Employment relationship
  - Who Wants to Know
    - Nationwide Mutual Insurance V. Darden*



# Professional Performance Practices and Profitability

**3401 (d)**

**person having control of the  
payment of such wages....**

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# Professional Performance Practices and Profitability

## *NAPEO Model State Statute*

- **28 states with PEO laws**
  - sharing and allocation of rights
  - reserving certain rights

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# Professional Performance Practices and Profitability

## *Employment not Insurance*

Transacting insurance –  
“solicitation or inducement”  
“preliminary negotiations”

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# Professional Performance Practices and Profitability

## Source of Cheap Insurance?

- Driven by Sales Targets or Profitability
- Underwriting
- Delivering Real Change

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# Professional Performance Practices and Profitability

## HR Services or Unlicensed Sale of Insurance

- Sharing Commissions
- Employer Fiduciary
- Controlled Business
- Terms of Art

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# Professional Performance Practices and Profitability

## Deceptive Sales Practices

*“false, misleading or deceptive  
acts or practices.....”*

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# Professional Performance Practices and Profitability

## Payment of Wages and Taxes

- Who is ultimately responsible
  - PEO or
  - Business client or
  - Both????



# Professional Performance Practices and Profitability

## *Termination*

- **Two separate acts**
  - Client termination
  - PEO termination



# Professional Performance Practices and Profitability

## PEO Employee Handbook

- **Business Tool**
  - Attracting and retaining the best
- **Liability Tool**
  - CSA
  - Employee Handbook

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# Professional Performance Practices and Profitability

## NAIC Model PEO Workers' Comp Rule

- **Master Policy**
- **Client-based Policy**
- **Multiple Coordinated Policy**

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# Professional Performance Practices and Profitability

## NAIC Model PEO Workers' Comp Rule

- **Full Workforce**

- “a PEO agreement under which the PEO agrees to assume specified employment responsibilities for all of the client’s employees within the state.”

- **Partial Workforce**

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## Professional Performance Practices and Profitability

### NAIC Model PEO Workers' Comp Rule

- **Transparency**
  - “The PEO shall not make any materially inaccurate, knowingly, or recklessly misleading or fraudulent misrepresentations to the client of the cost of workers’ compensation coverage”

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# Professional Performance Practices and Profitability

## NAIC Model PEO Workers' Comp Rule

- **Termination**

- “Cancellation or non-renewal of a client’s coverage at the initiative of the PEO without the written consent of the client is not effective as to the client unless the PEO has given at least 30 days’ advance notice to the client and the workers’ compensation regulator.”

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## Professional Performance Practices and Profitability

### NAIC Model PEO Workers' Comp Rule

- **Multiple Coordinated Policy (MCP)**
  - Name of the PEO with client additional insured
  - Name of the client with PEO additional insured
  - “Labor Contractor For”

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# Professional Performance Practices and Profitability

**NCOIL**

**National Conference of Insurance  
Legislators Model Rule**

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# Professional Performance Practices and Profitability

**NCCI**

**The National Council of  
Compensation Insurance, Inc.**

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# Professional Performance Practices and Profitability

- **File and Use**
- **MCP or client based policy???**



# Professional Performance Practices and Profitability

## **Would the Real MCP Please Stand Up**

- **NAIC MCP**
  - Experience rating
  - Proof of coverage

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# Professional Performance Practices and Profitability

**NCCI “MCP”**

- **Named Insured**
  
- **Combinability**

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## Professional Performance Practices and Profitability

- A change in rate or rate structure of policy initiative?
- Where is the camel's nose?



# Professional Performance Practices and Profitability

## 9 Most Important Laws

- **FLSA**
  - Employer to keep track of hours
- **Title VII of the Civil Rights Act**
  - Unlawful discharge
- **ERISA**
  - Fiduciary responsibility

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# Professional Performance Practices and Profitability

## 9 Most Important Laws

- **COBRA**
  - Notice of eligibility
- **IRCA Immigration Reform & Control**
  - Form I-9
- **OSHA**
  - Workplace safety

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# Professional Performance Practices and Profitability

## 9 Most Important Laws

- **HIPAA Health Insurance Portability and Accountability Act**
  - Preexisting conditions
- **ADEA Age Discrimination in Employment Act**
  - Terminations and conditions of benefits
- **FMLA**
  - Unpaid leave

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# Professional Performance Practices and Profitability

## 10 Foundational Legal Principles

- **Statutory Recognition**
- **PEO as an Employer of Record**
- **PEO insurable interest**
- **PEO right to SUTA**
- **PEO Employee Benefit Plan Sponsor**

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# Professional Performance Practices and Profitability

## 10 Foundational Legal Principles

- **MEWAs and Self-Insurance**
- **Liability limit to Expressly Allocated in CSA**
- **Client Access to Tax Credits**
- **Calculation of Taxes and Receipts**
- **Promotion of Best Practices**

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Professional Performance Practices  
and Profitability

# Professional Employer Organizations

*Changing the  
Business of Employment*

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# Professional Performance Practices and Profitability

**Milan P. Yager**

Executive Vice President

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The Official Publication of the National Association of Professional Employer Organizations

# PEO INSIDER

# Redefining

## THE EMPLOYMENT RELATIONSHIP







**2007**  
**South Carolina**  
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**Seminar**

**Monday, September 27, 2007**

HIRING OF FOREIGN WORKERS  
AND  
IDENTITY THEFT

TOM SHEAFFER

## Thomas (Tom) A. Sheaffer

**Personal:** Married 32 years to wife Terri. Have 2 children, Scott and Melissa. All of us happily live in the Upstate of South Carolina in Fountain Inn. We have lived in South Carolina for 23 years.

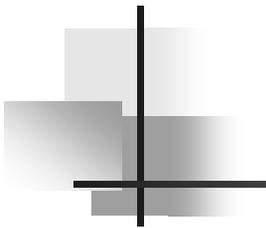
**School:** Graduate of the University of South Carolina with a B.S. in Management and Economics (dual majors.)

**Work History:** Currently with the IRS since 2001 as a Senior Tax Specialist. While with the IRS I have been responsible for building Partnerships and Coalitions with IRS Stakeholders. Most of this experience has been in the Wage and Investment Division, which serves taxpayers filing Form 1040 (W-2 recipients and Pensioners.) During this time I have:

1. Helped write the current Volunteer Tax Preparation Training Manual and contributed to the Online Training component of the manual (Link and Learn) at [irs.gov](http://irs.gov),
2. Facilitated the creation of 3 EITC Coalitions in the Upstate of SC preparing over 2,000 tax returns for low income wage earners annually,
3. Served on the International Military Volunteer Return Preparation Team training military "volunteers" on in Korea and Japan,
4. Appeared on numerous TV and radio programs throughout the state each year explaining changes and "hot topics" in tax law.

Currently I am the Industry Liaison for South Carolina in the Small Business/Self Employed unit.

Prior to the IRS, I worked 25 years as a multi-unit supervisor for Shoney's largest franchise, TPI restaurants.



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# **Internal Revenue Service**

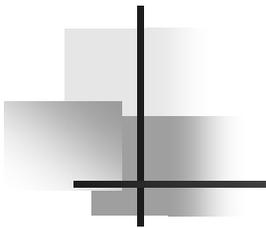
## **Individual Taxpayer Identification Number (ITIN)**

**Tom Sheaffer**

**IRS Small Business, Self Employed**

**Senior Tax Law Specialist**

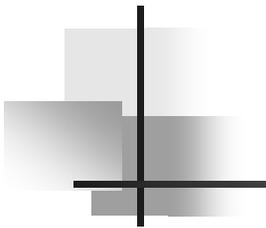




# Purpose of ITINs

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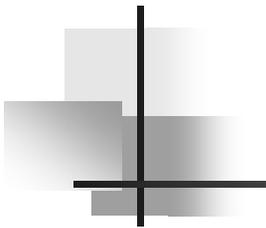
Individual Taxpayer Identification Numbers (ITIN) are used for federal tax purposes only and provide a means to efficiently process and account for tax returns and payments.



# Changes Made to Program

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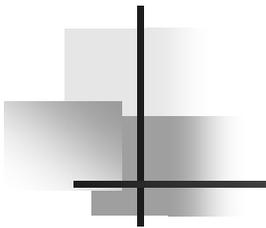
- All new ITIN applicants must show a federal tax purpose for seeking the ITIN. With some exceptions this requires attaching a valid original individual income tax return.
- Reduced to 13 from 40 the number of documents acceptable as proof of identity to obtain an ITIN.
- Changed the appearance of the ITIN from a card to an authorization letter to avoid similarities to SSN Card.



# An IRS ITIN is...

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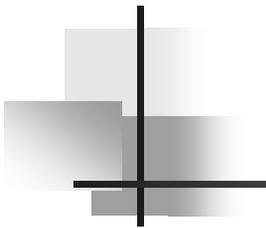
- A tax processing number
- An ITIN is a unique 9 digit tax processing number beginning with "9" with the middle two digits ranging from 70 to 80 (9XX-70-XXXX)
- The ITIN is issued to individuals required to pay tax or who have a tax reporting requirement to the IRS but do not qualify for a Social Security Number.



# An ITIN does NOT...

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- Entitle the recipient to Social Security benefits or Earned Income Tax Credit (EITC).
- Change an individual's immigration status.
- Give the individual the right to work in the U.S.
- Serve as identification outside the tax system.
- Is not for employment purposes.



# Who Needs an ITIN?

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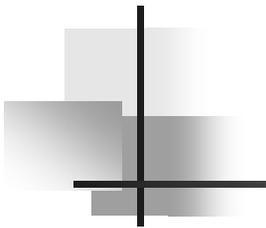
Any U.S. resident or non-resident alien individual who:

- is required to file a U.S. federal income tax return
- can be claimed as an exemption on a U.S. federal income tax return
- does not have and cannot obtain an SSN
- meets an exception to having to file a U.S. federal income tax return, but requires an ITIN for federal reporting purposes.

# There are Exceptions to the Return Filing Requirement ...

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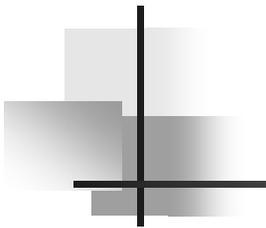
- **Exception 1:** Passive Income -treaty benefits
- **Exception 2:** Other Income (wages, salary, compensation)
- **Exception 3:** Third party Withholding – Mortgage interest
- **Exception 4:** Disposition by foreign person of U.S. Real Property Interest- withholding obligations



# Reference

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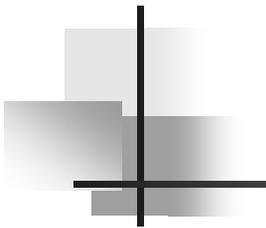
- [www.irs.gov](http://www.irs.gov) keyword ITIN
- Publication 4327 – ITIN - Facilitating Participation in the Tax System
- Revenue Procedure 2006-10 (Jan. 9, 2006)
- Publication 4393 - *What is an IRS **ITIN** Acceptance Agent*



# ***What is the Tax Gap?***

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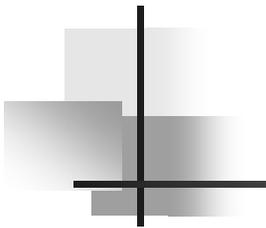
**The difference between the amount of tax that taxpayers should pay for a given year and the amount that is paid voluntarily and timely.**



# ***How big is the Tax Gap?***

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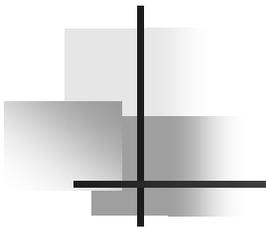
- **Total = \$345 billion (Tax Year 2001)**
  - **Nonfiling = \$27 billion**
  - **Underpayments = \$33 billion**
  - **Underreporting = \$285 billion**



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# ***What is being underreported?***

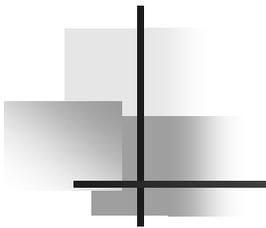
- **Unreported small business income and self-employment tax = \$148 billion**
  - Unreported income
  - Over-reported expenses
- **43 percent of total tax gap**

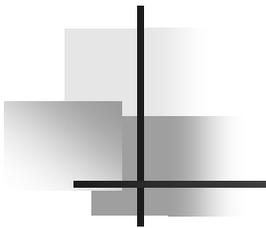


# I-9 Forms

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- Disclaimer!
- [WWW.ice.gov](http://WWW.ice.gov)
- Background

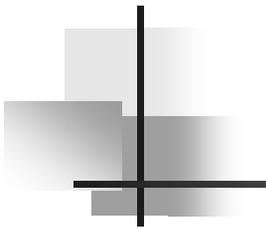
- 
- 
- All employees hired after November 6, 1986 must complete section 1.
  - Translator/Preparer
  - Section 2 - Employer



## Within 3 business days:

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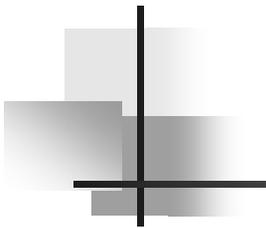
- Must examine documents,
- Must complete Section 2,
- Making photocopies is recommended.
- Employers can not specify which document will be accepted.



# IMAGE Program

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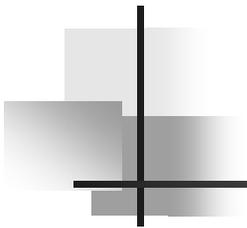
- Voluntary Program
- Submit to I-9 Audit by ICE
- Verify Social Security Numbers of existing labor force using Social Security Number Verification System (SSNVS)
- <https://www.vis-dhs.com/EmployerRegistration/>.



# Resident or Nonresident?

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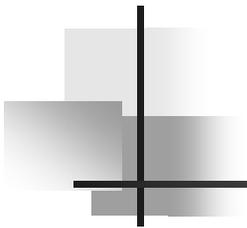
- Substantial Presence Test
- Green Card Test
- Residency Through Marriage



# Substantial Presence Test

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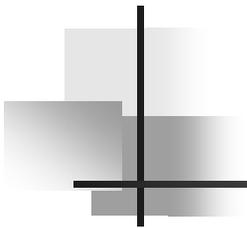
- 31 days during the current year, and
- At least 183 days during the three year period ending with the current year



# Exempt Individuals

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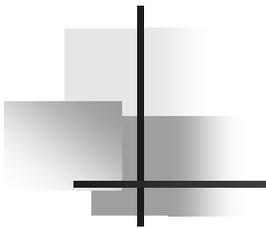
- F, J, M, & Q student status holders
- J & Q teacher or trainee status holders
- Not exempt from taxation



# Exempt students (F & J)

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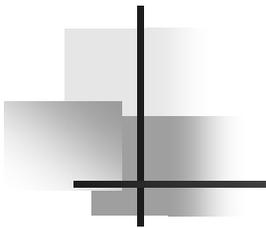
- 5 years
- Dependents are generally included
- All must file Form 8843



## Establishing a Closer Connection

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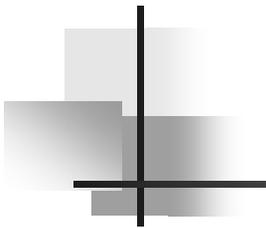
- present in the U.S. less than 183 days in the current year
- have a tax home in a foreign country
- file Form 8840.



# Green Card Test

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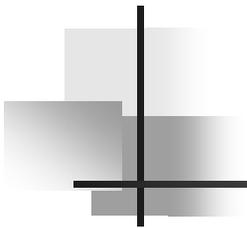
- Date of adjustment to status--not the date pink 'green card' issued
- No option--if you are a Permanent Resident, you are a resident for tax purposes



# Residency Starting Date

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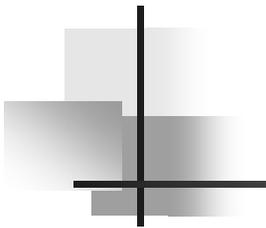
- Passes Substantial Presence Test
- Granted permanent residence status--  
green card test
- When both apply use the earlier of the  
two



# Residency through marriage

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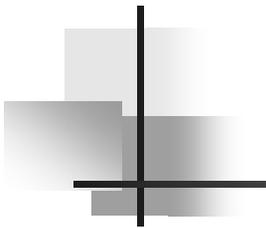
- Nonresident spouse can be treated as a resident
  - Required to file jointly
  - Report world-wide income



# Dual-status Aliens

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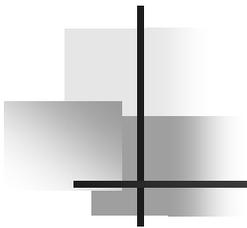
- Taxpayer has two residency statuses during the same tax year
- Must file two returns
- Allocate income



# Employers now need to identify employee's tax status!

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**New procedure for withholding income taxes on the wages of nonresident alien employees.** For wages paid on or after January 1, 2006, employers are required to apply a new procedure in calculating the amount of federal income tax withholding on the wages of nonresident alien employees. For more information, see *New procedure for withholding income taxes on the wages of nonresident alien employees* on page 14.



## Publication 15 has the rules for this.

**New procedure for withholding income taxes on the wages of nonresident alien employees.** In general, you also must withhold federal income taxes on the wages of nonresident alien employees. However, see Publication 515 for exceptions to this general rule. For wages paid on or after January 1, 2006, you are required to apply a new procedure in calculating the amount of federal income tax withholding on the wages of nonresident alien employees. Under this procedure, you add an amount as set forth in the chart below to the nonresident alien's wages solely for calculating the income tax withholding for each payroll period. You determine the amount to be withheld by applying the income tax withholding tables to the amount of wages paid plus the additional chart amount. For more information, see Notice 2005-76. You can find Notice 2005-76 on page 947 of Internal Revenue Bulletin 2005-46 at [www.irs.gov/pub/irs-irbs/irb05-46.pdf](http://www.irs.gov/pub/irs-irbs/irb05-46.pdf).

The amount to be added to the nonresident alien's wages to calculate income tax withholding is set forth in the following chart.

## Amount to Add to Nonresident Alien Employee's Wages for Calculating Income Tax Withholding Only

<u>Payroll Period</u>	<u>Add Additional</u>
Weekly	\$ 51.00
Biweekly	102.00
Semimonthly	110.00
Monthly	221.00
Quarterly	663.00
Semiannually	1,325.00
Annually	2,650.00
Daily or Miscellaneous (each day of the payroll period)	10.20

**Note.** Nonresident alien students from India and business apprentices from India are not subject to this procedure.

The amounts added under this chart are added to

# 1099 MISC Withholding

- Importance of the W-9
- What is a W-8, W-8BEN, W-8EIC?

- 
- 
- Form W-9. Generally, you can treat the payee as a U.S. person if the payee gives you a Form W-9. The Form W-9 can only be used by a U.S. person and must contain the payee's taxpayer identification number (TIN). If there is more than one owner, you may treat the total amount as paid to a U.S. person if any one of the owners gives you a Form W-9. See *U.S. Taxpayer Identification Numbers*, later. U.S. persons are not subject to NRA withholding, but may be subject to Form 1099 reporting and backup withholding.
- 
- Form W-8. Generally, a foreign person that is a beneficial owner of the income should give you

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## Documentation

Generally, you must withhold 30% from the gross amount paid to a foreign payee unless you can reliably associate the payment with valid documentation that establishes either of the following.

- The payee is a U.S. person.
- The payee is a foreign person that is the beneficial owner of the income and is entitled to a reduced rate of withholding.

Generally, you must get the documentation before you make the payment. The documentation is not valid if you know, or have reason to know, that it is unreliable or incorrect. See *Standards of Knowledge*, later.

If you cannot reliably associate a payment with valid documentation, you must use the presumption rules discussed later. For example, if you do not have documentation or you cannot determine the portion of a payment that is allocable to specific documentation, you must use the presumption rules.

The specific types of documentation are discussed in this section. You should, however, also see the discussion, *Withholding on Specific Income*, as well as the instructions to the particular forms. As the withholding agent, you may also want to see the Instructions for the Requester of Forms W-8BEN, W-8ECI, W-8EXP, and W-8IMY.

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## Documentation

Generally, you must withhold 30% from the gross amount paid to a foreign payee unless you can reliably associate the payment with valid documentation that establishes either of the following.

- The payee is a U.S. person.
- The payee is a foreign person that is the beneficial owner of the income and is entitled to a reduced rate of withholding.

Generally, you must get the documentation before you make the payment. The documentation is not valid if you know, or have reason to know, that it is unreliable or incorrect. See *Standards of Knowledge*, later.

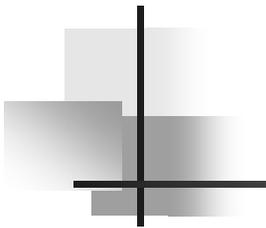
# Form 1042-S

This document contains interactive form fields.

Highlight fields

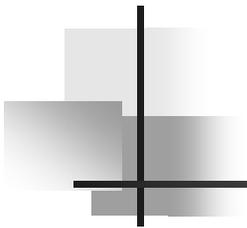
Form <b>1042-S</b>		<b>Foreign Person's U.S. Source Income</b>				<b>2006</b>		OMB No. 1545-0096	
Department of the Treasury Internal Revenue Service		<input type="checkbox"/> <b>AMENDED</b>		<input type="checkbox"/> <b>PRO-RATA BASIS REPORTING</b>		<b>Copy A</b> for Internal Revenue Service			
<b>1</b> Income code	<b>2</b> Gross income	<b>3</b> Withholding allowances	<b>4</b> Net income	<b>5</b> Tax rate	<b>6</b> Exemption code	<b>7</b> U.S. Federal tax withheld	<b>8</b> Amount repaid to recipient		
<b>9</b> Withholding agent's EIN ▶ <input type="checkbox"/> EIN <input type="checkbox"/> QI-EIN				<b>14</b> Recipient's U.S. TIN, if any ▶ <input type="checkbox"/> SSN or ITIN <input type="checkbox"/> EIN <input type="checkbox"/> QI-EIN					
<b>10a</b> WITHHOLDING AGENT'S name Check here if nominee <input type="checkbox"/>				<b>15</b> Recipient's country of residence for tax purposes			<b>16</b> Country code		
<b>10b</b> Address (number and street)				<b>17</b> NONQUALIFIED INTERMEDIARY'S (NQI's)/ FLOW-THROUGH ENTITY'S name			<b>18</b> Country code		
<b>10c</b> Additional address line (room or suite no.)				<b>19a</b> NQI's/Flow-through entity's address (number and street)					
<b>10d</b> City or town, province or state, and country		<b>10e</b> ZIP code or foreign postal code		<b>19b</b> Additional address line (room or suite no.)					
<b>11</b> Recipient's account number (optional)			<b>12</b> Recipient code			<b>19c</b> City or town, province or state, and country		<b>19d</b> ZIP code or foreign postal code	
<b>13a</b> RECIPIENT'S name				<b>20</b> NQI's/Flow-through entity's TIN, if any ▶					
<b>13b</b> Address (number and street)				<b>21</b> PAYER'S name and TIN (if different from withholding agent's)					
<b>13c</b> Additional address line (room or suite no.)				<b>22</b> State income tax withheld		<b>23</b> Payer's state tax no.		<b>24</b> Name of state	
<b>13d</b> City or town, province or state, and country		<b>13e</b> ZIP code or foreign postal code							

For Privacy Act and Paperwork Reduction Act Notice, see page 15 of the separate instructions. Cat. No. 11386R Form **1042-S** (2006)



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The 1042-S in many instances also be required even though you are hiring that person as an employee and issuing a W-2!



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?????Questions?????

# IRS Identity Theft Program

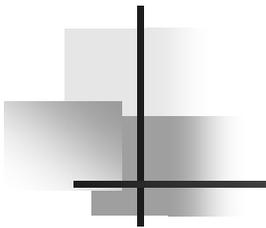


**Presenters Name  
And Title**

# What is Identity Theft?

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A fraud committed, or attempted, by using the identifying information of another person without their authority.



# What is “Phishing”?

---

Phishing is the act of sending an email to a user falsely claiming to be a legitimate enterprise in an attempt to scam the user into surrendering private information that can be used for identity theft.

# Facts about Identity Theft

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- Identity theft is rarely a stand alone crime
- Identity theft is a costly crime
  - Estimated 10 million victims in U.S.
  - \$5 billion annual cost to victims
  - almost 300 million hours to restore their good names

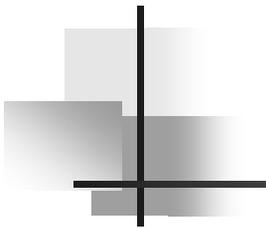
information can be found @ [IDtheft.gov](http://IDtheft.gov)

# Most Common Types of Identity Theft and Fraud

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- **25% - Credit Card**
- **16% - Phone &/or Utilities**
- **16% - Bank**
- **14% - Employment**
- **10% - Government Documents/Benefits**
- **5% - Loan**

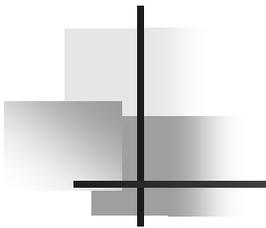
Source - <http://www.consumer.gov>



# Personally Identifiable Information

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- **Full name** (if not common)
- **Social Security number**
- **Birth date**
- **Tax return information**
- **Phone number**
- **Street address**
- **Driver license number**



# Personally Identifiable Information

---

- **Passport information**
- **Credit card information**
- **Bank account information**
- **Business contact information**
- **Salary Information**
- **Email address**

# A thief can obtain your personal identifiable information by...

- **Using technology:**

- Phishing - Hacking and Trojans
- Skimming - Social Engineering

- **Using less sophisticated methods:**

- Dumpster Diving
- Changing Your Address
- Stealing Mail, Wallet or Purse



# How Identity Theft Impacts Taxpayers:

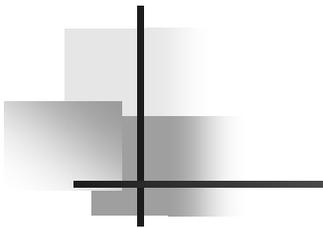
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- **Refund Crimes**
- **Employment**
- **Income Diversion**
- **Preparer Schemes**

# How Identity Theft Impacts IRS

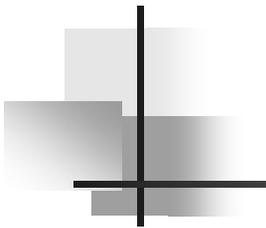
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- Automated Underreporter (AUR)
- Mixed Entity
- Scrambled SSN
- Individual Taxpayer Identification Number (ITIN)
- Refund redirection



# Most Common Identity Theft Issues Received By IRS...

- Identity stolen - no indication of tax usage
- Underreporter notice received
- Knowledge of person filing with stolen SSN
- Multiple taxpayers using same SSN
- Request for a new SSN



# **What is the IRS doing to combat identity theft?**

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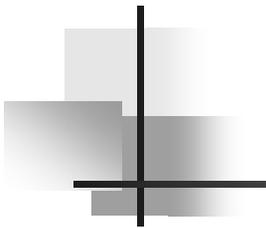
**IRS has created an Identity Theft  
Program to provide:**

- **Outreach**
- **Victim assistance**
- **Prevention**
- **Future activities**

# What you can do to protect your identity?

---

- **Stay Informed:**
  - Check your credit report
  - Review your bank and credit card statements
- **Report incidents of ID Theft**
- **Secure personal information**



# What you can do to protect your identity?

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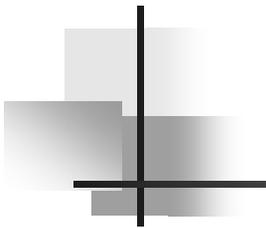
- **Challenge requestors**
- **Shred / destroy documents**
- **Secure documents**

# What you can do to protect your identity?

---

- **Secure your computer - Encrypt**
- **IRS does not initiate email contact to request personal information**
- **Forward or send suspicious email to:**

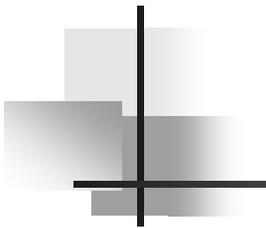
[phishing@irs.gov](mailto:phishing@irs.gov)



# IRS Resources

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- **IRS.gov keyword search  
"Identity Theft"**
- **Contact IRS at 1-800-829-1040**
- **Contact Taxpayer Advocate  
Service  
at 1-877-275-8271**



# IRS Resources

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- Publication 4469 - *Identity Theft - Outsmarting the Crooks*
- Publication 4524 - *Security Awareness*
- Publication 4535(EN/SP) - *Identity Theft Prevention and Victim Assistance*
- Publication 4523(EN/SP) - *Beware of Phishing*



**2007**  
**South Carolina**  
**Professional Employer Organization**  
**Continuing Professional Education**  
**Seminar**

**Monday, September 27, 2007**

LARGE DEDUCTIBLES IN AN IDEAL WORLD

LYNN E. SZYMONIAK

Lynn Szymoniak has practiced law in West Palm Beach, Florida, since 1980. She primarily represents insurance companies in premium fraud litigation. She also lectures, writes articles and has served as an expert witness for the Justice Department. She is a graduate of Villanova Law School and Bryn Mawr College.

## LARGE DEDUCTIBLES IN AN IDEAL WORLD

By Lynn E. Szymoniak / [szymoniak@mac.com](mailto:szymoniak@mac.com)  
September 27, 2007 – Columbia, South Carolina

In a Good Deductible Program, payments are made for premium and loss fund ONLY.

An insurer should not require payments characterized as "preferred stock" or "deposits held by the holding company" or other charges.

The contract should specify:

1) any cost for taxes and assessments has been included in the deductible premium offered and is the sole responsibility of the insurer;

2) any cost for Allocated Loss Adjustment Expense (ALAE) has been included in the deductible premium offered and is the sole responsibility of the insurer. ALAE are loss adjustment expenses that can be attributed to a specific claim. LAE are expenses incurred while determining the value of a claim, over and above the cost of the claim. These can include fees from doctors, trial lawyers, expert witnesses fees, deposition costs, and adjusters.

3) any cost for Unallocated Loss Adjustment Expense (ULAE) has been included in the deductible premium offered and is the sole responsibility of the insurer. ULAE are adjustment expenses that result from a broad array of claims or that result from the general process of determining the amount of claims payments.

**PRACTICE TIP:** Review The Deductible Agreement/ Insurance Proposal Carefully To Discover Any Hidden Charges

In a Good Deductible Program, there will be an initial deposit, and a loss fund which can be paid on an installment plan or pay-as-you-go plan.

The contract should specify:

1) that the insurer will bill weekly as a percent of manual premium so that the loss fund grows as the PEO grows. This helps to avoid cash calls because the exposure outgrew the estimated loss fund.

2) that audits will be done quarterly. This prevents the insurer from re-classifying payroll or including excluded sub-contractor payroll resulting in a large unexpected debt after the policy ends. Determine who pays for the quarterly audits and the maximum charge. Auditing is an insurer's obligation. The insured should not be billed for routine audits.

In a Good Deductible Program, contracts, costs and policy terms are available for review well in advance of the date coverage is needed.

**PRACTICE TIP: USE BOTH AN ATTORNEY AND AN EXPERIENCED AGENT TO REVIEW THE AGREEMENT/INSURANCE PROPOSAL AND IDENTIFY AND AMBIGUITIES OR OMISSIONS. MOST ATTORNEYS WILL NOT HAVE THE REQUIRED EXPERTISE, ESPECIALLY TO IDENTIFY OMISSIONS.**

**PRACTICE TIP: KNOW YOUR INSURER'S TRACK RECORD. CHECK FOR LAWSUITS FILED BY OR AGAINST THE INSURER BY OTHER PEOS OR LARGE RISKS.**

In a Good Deductible Program, a dispute resolution mechanism for the most common disputes arising at audit has been included in the contract.

In a Good Deductible Program, an aggregate stop/loss feature is available.

An important aspect that the broker needs to evaluate when analyzing a large deductible plan is the aggregate stop loss limit. The aggregate stop loss limit is the total amount that the insured could be obligated to pay for losses under the deductible. For example, if the aggregate stop loss limit is \$1,000,000 and the combined losses for the insured is currently \$900,000. If a claim occurred for \$200,000, then the insured would only pay \$100,000 because at this point the aggregate stop loss limit would be reached. The insurance company would pay the additional \$100,000 and all losses for the rest of the policy period. If an insured had a deductible plan without an aggregate stop loss limit, multiple losses could have an adverse impact on earnings. The aggregate stop loss limit is usually set at around 1.5 to 2 times the loss projection.

#### LARGE DEDUCTIBLES IN AN IDEAL WORLD

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In a Good Deductible Program, the insured/PEO is not required to participate in any other "risk-sharing" agreement.

**PRACTICE TIP: AVOID ANY PROGRAM WHICH OFFERS COVERAGE THROUGH AN OFFSHORE OR A CAPTIVE FOR CLAIMS WITHIN THE DEDUCTIBLE LAYER. THESE ARRANGEMENTS HAVE BEEN THE SOURCE OF MANY DISPUTES AND LITIGATION.**

**PRACTICE TIP: AVOID ANY PROGRAM WHERE THE INSURED IS REQUIRED TO PURCHASE RE-INSURANCE THROUGH AN OFFSHORE OR CAPTIVE RISK-SHARING AGREEMENT.**

In a Good Deductible Program, the insurer will disclose the reinsurer(s), their ratings, and the re-insurers layers of protection for excess loss.

**PRACTICE TIP: BEWARE OF THE RE-INSURANCE JARGON. RED FLAG: WHEN THE INSURER CASUALLY MENTIONS HIS TRIPS TO LONDON TO MEET WITH "LLOYDS" OR "THE BOYS FROM LLOYDS."**

In a Good Deductible Program, the contract should specify the bank(s) in which the collateral is held and whether it is interest-bearing. There should be no co-mingling of premium and loss funds. The bank must be satisfactory, recognized, rated and within the USA.

**PRACTICE TIP: DETERMINE THE INSURERS'S PROTOCOLS USED TO ESTABLISH THAT LETTERS OF CREDIT ARE VALID.**

In a Good Deductible Program, the timeframe for return of premium/loss fund collateral is specified in the contract.

In a Good Deductible Program, the insurer can provide references of other PEOs which are satisfied with the program and services - particularly, the audit process.

**PRACTICE TIP: CHECK THE A.M. BEST RATING; READ THE MARKET CONDUCT EXAMINATIONS; CHECK THE LITIGATION HISTORY OF THE CEO, PRESIDENT AND BOARD CHAIRMAN.**

In a Good Deductible Program, the TPA is a critical element.

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**PRACTICE TIP: GET REFERENCES FROM THE TPA OF OTHER PEOS OF THE SAME SIZE OR LARGER HANDLED SUCCESSFULLY BY THIS TPA. ASK WHETHER THE BILLING HAS BEEN CONSISTENTLY TIMELY.**

Other areas of inquiry:

- 1) will special claims handling procedures will be followed;
- 2) what are the TPA's reserving practices;
- 3) what is the TPA's litigation rate;
- 4) what is the TPA's average cost per claim;
- 5) what is the TPA's closure rate;
- 6) what is the TPA's average ALAE;
- 7) what are the average case loads;
- 8) will the TPA handle or outsource subrogation;
- 9) what is the experience level of the Lost Time adjustors;

**In a Good Deductible Program, both parties will know what events will trigger the calling of the Letters of Credit.**

**PRACTICE TIP: DETERMINE WHAT LOSS DEVELOPMENT FACTORS (LDF'S) WILL BE USED TO PROJECT ULTIMATE LOSS.**

The loss development to ultimate loss is what generally triggers LOC draw downs or cash calls for additional funds. What method will be used:

- 1) Paid Loss Development;

From Standard & Poors:

The data used includes paid losses—including defense and cost-containment expenses. for the accident year by evaluation date. The factors are then used to predict how paid losses for more recent accident years will change in future calendar years. Under the five-year

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 September 27, 2007  
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simple average, the five age-to-age factors for the five most recent accident years are averaged. Under the five-year weighted average, the sum of cumulative paid losses including defense and cost-containment expenses for calendar period  $t+12$  is compared with that for period  $t$  ( $t=12$  months, 24, 36, etc., up to 108). The ratio of paid losses including defense and cost-containment expenses for period  $t+12$  to that of period  $t$  is the five-year weighted average. Finally, under the five-year excluding Hi-Lo selection, the highest and the lowest age-to-age factors for the most recent five accident years are excluded, and the average of the remainder of the three factors are then averaged.

Standard & Poor's selected the five-year weighted average as the most appropriate loss development factor because it maintains a balance between stability and responsiveness in developing age-to-age factors. These individual age-to-age factors are used in conjunction with the industrywide benchmark tail factors to obtain age-to-ultimate factors. The estimate of ultimate losses for each accident year is then obtained by multiplying the cumulative paid losses by the appropriate age-to-ultimate factor. Standard & Poor's also uses industrywide loss development factors to make an additional independent estimate of projected losses.

In addition to the factors derived from company-paid losses and the industrywide factors, the analysis might include adjustments to these factors based on company-specific situations. This would result from discussions with company management.

## 2) Incurred Loss Development;

From Standard & Poors:

The incurred loss development method is similar to the paid loss development method except that case-incurred losses are used instead of paid losses. Case-incurred losses are defined as the sum of accident-year paid losses plus accident-year case reserves.

As with the paid loss development methodology, various development factors are calculated for the accident years under study. The five-year weighted average is again selected as the most appropriate selection because it maintains a balance between stability and responsiveness in the factors. The average factors are then used to project losses from more recent accident years into the future. Again, this is accomplished by multiplying the case-incurred losses for each accident year as of a given accounting date by the appropriate factor. As with the paid loss development method, Standard & Poor's uses industrywide tail factors to project losses beyond 10 years. Standard &

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Poor's also uses industrywide factors to make an additional independent estimate of projected losses.

In addition to the factors derived from the case-incurred losses and the industrywide factors, the analysis might include adjustments to these factors based on company-specific situations. This would result from discussions with company management.

### 3) Bornheutter-Fergusson Method;

From Standard & Poors:

The Bornheutter-Ferguson method is used mainly for reinsurance and when limited data is available and estimates of IBNR claims are difficult, if not impossible, to make from actual company data. IBNR claims are defined as claims as of a given date that have occurred and are the company's responsibility but have not been reported to the company or have not been recorded on the company's books. An example of when one might use the Bornheutter-Ferguson method would be a company entering a new line of business or one having insufficient data points on a long-tail line of business.

There are several ways to apply this method. In general, an estimate of ultimate incurred losses is made independent of present loss-reserve levels. IBNR reserves are then estimated by applying independent estimates of reporting patterns to the ultimate incurred-loss estimate and are added to actual reported losses to derive total incurred losses for the line of business. An independent estimate of ultimate incurred losses is made by multiplying the company-earned premiums by expected ultimate loss ratios. The industrywide estimate of this ratio is used. This ratio is calculated by line of business and by accident year. The selected percentages of ultimate loss reported and unreported are again based on industrywide estimates. IBNR reserves are derived by multiplying the expected ultimate incurred loss from above by the percentage unreported. Actual reported incurred losses are then added to the IBNR estimate to derive projected ultimate incurred losses.

### 4) Insurance Company's Own date;

### 5) PEO's Own Data.

**PRACTICE TIP: BEWARE OF POTENTIAL DISTORTIONS IN ULTIMATE LOSS CALCULATIONS**

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From Standard & Poors:

A virtually unlimited number of company-specific situations can distort the results obtained from the above methodologies. Through discussions with company management and the reserve questionnaire responses, Standard & Poor's can identify the most important adjustments needed. Listed below are the more common distortions

Standard & Poor's has encountered:

Changes in claims personnel. If staff has been added, payments will likely be made at a quicker rate, distorting the paid loss development age-to-age factors. These factors need to be adjusted to reflect the differing levels between present payments and historical payments. If staff has been reduced, a similar but opposite adjustment might be warranted. In both cases, incurred loss development will be more stable and present more reliable results.

Changes in claims department philosophy. If claims are being assigned an average case amount, and this amount is changed (which happens often), using the data before the change to project losses after the change will give distorted results. As another example, management might push to get claims off the books as quickly as possible. This would cause distortions similar to those when claims staff is added. The treatment of independent adjusters or legal services, or a switch from or to the use of independent adjusters or legal services, can also have an effect on the loss development, especially for long-tail, third-party lines of business.

External occurrences. This is very common for workers' compensation in which automatic benefit- and income-level changes and legal changes are frequent. In these cases, it is important to ascertain when the change took place as well as how it is being applied (i.e., to all claims or only those as of a certain date).

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September 27, 2007  
Columbia, S. C.

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF TEXAS  
SHERMAN DIVISION

**RECEIVED**  
U.S. DISTRICT COURT  
EASTERN DISTRICT OF TEXAS

APR 20 2007

DAVID J. MALAND, CLERK  
BY  
DEPUTY \_\_\_\_\_

Providence Property & Casualty Insurance §  
Company, and Imperial Casualty and §  
Indemnity Company, §  
§

Plaintiffs, §

vs. §

Paradyme, Inc. d/b/a Presidion §  
Solutions IV, Inc., §  
§

Defendant. §

C.A. NO. 4:07cv202

**COMPLAINT**

Plaintiffs Providence Property & Casualty Insurance Company (“Providence”) and Imperial Casualty and Indemnity Company (“Imperial”) file this Complaint against Defendant Paradyme, Inc. d/b/a Presidion Solutions IV, Inc. (“Presidion”) and state:

**PARTIES**

1. **Providence.** Plaintiff Providence is an Oklahoma corporation with its principal place of business in Frisco, Texas. For purposes of jurisdiction, Providence is a citizen of Texas.

2. **Imperial.** Plaintiff Imperial is an Oklahoma corporation with its principal place of business in Frisco, Texas. For purposes of jurisdiction, Imperial is a citizen of Texas.

3. **Presidion.** Defendant Presidion is a Florida corporation with its principal place of business in Troy, Michigan. Presidion does business in Texas, but its registered agent resigned, and one is not currently appointed in the State of Texas. Therefore, Presidion may be served with process through the Texas Secretary of State at 1019 Brazos Street, Austin, Texas 78701, pursuant to TEX. CIV. PRAC. & REM. CODE § 17.041, et seq., who is instructed to promptly mail a copy of this Complaint and the Summons to Presidion's home office at 755 W. Big Beaver Rd., Suite 1700, Troy, Michigan 48084. For purposes of jurisdiction, Presidion is a citizen of Michigan or Florida.

#### **JURISDICTION AND VENUE**

4. **Jurisdiction.** The Court has jurisdiction over this civil action pursuant to 28 U.S.C. § 1332, as the amount in controversy exceeds the sum or value of \$75,000.00, exclusive of interests and costs, and there is complete diversity of citizenship between the parties.

5. **Venue.** Venue is proper in this district and division under 28 U.S.C. § 1391, as a substantial part of the events or omissions giving rise to the claims occurred in this district and division.

#### **OPERATIVE FACTS**

6. **Providence and Imperial's Business.**

A. **Generally.** Providence and Imperial provide workers' compensation insurance to professional employer organizations ("PEOs"). Businesses often retain a PEO to handle the businesses' human resource responsibilities. As it

relates to this dispute, PEOs also obtain workers' compensation insurance for the businesses and their employees. When a PEO seeks workers' compensation insurance, Providence and Imperial, after reviewing the financial strength and history, as well as the management of the PEOs, underwrite the PEO's clients (the businesses), issue a master policy to the PEO and issue certificates of insurance to the businesses. Typically, these policies carry a large, per claim deductible of \$250,000 to \$1,000,000.00.

**B. Claim Administration.** As with any deductible, the PEO is responsible for any claim up to the amount of the deductible, with Providence and Imperial obligated to pay a claim in excess of the deductible. However, Providence and Imperial administer *all* claims under a policy, regardless of whether the deductible will be reached. In this instance, Providence and Imperial will establish an original estimate for the cost of a claim (the "Incurred Amount"). Providence and Imperial then invoice the PEO for the Incurred Amount, and the PEO must pay within five days after receiving an invoice.

**C. State Assessments.** Many states will levy "assessments" connected to the provision of workers' compensation insurance. By agreement, it becomes the PEO's responsibility to pay these assessments. Providence will make the assessment payment and obtain reimbursement from the PEO.

7. **Presidion.** Presidion is a PEO. As one of the services Presidion provides to its clients, Presidion obtains workers' compensation coverage for its clients' employees.

8. **Presidion Seeks Workers' Compensation Insurance.** Presidion sought workers' compensation insurance from Providence and Imperial. Providence and Imperial, after reviewing the financial strength and based upon the reputation and experience of its management, presented Presidion with a proposal for its workers' compensation needs, which Presidion accepted. The proposal sets forth the obligations of the parties, including Presidion's ultimate obligation to pay claims up to the deductible, advance Incurred Amounts after invoice, and reimburse Providence and Imperial for payment of assessments.

9. **The Master Policies.** Providence and Imperial issued master policies to Presidion (the "Master Policies"). The Master Policies were initially effective on July 9, 2004, for a term of one year. Presidion renewed the Master Policies subject to a renewal agreement effective July 1, 2005.

10. **The Non-Renewal.** Providence and Imperial elected not to renew the Master Policies effective July 1, 2006. Since that time, Presidion has failed and refused make any additional payments for the Incurred Amounts and state assessments on behalf of its employees.

11. **Unpaid Incurred Amounts.** Based on past claims experience with the Master Policies, Presidion has been billed \$289,565.72 for Incurred Amounts through March 31, 2007, but paid only \$218,596.84, leaving \$70,968.88 due and owing. Providence and Imperial made demand on Presidion, but it has failed and refused to make the requisite payments. These amounts will continue to increase until all claims under the Master Policies have been resolved.

12. **State Assessments.** Pursuant to the agreement, Presidion was responsible for the payment of the percentage of the assessments attributable to the Master Policies. To date, Presidion has been billed \$33,699.00 for state assessments, but paid only \$1,231.00, leaving \$32,468.00 due and owing. Providence and Imperial made demand on Presidion, but it has failed and refused to make the requisite payment. Likewise, these amounts will continue to increase until all claims under the Master Policies have been resolved.

### **CAUSES OF ACTION**

13. **Breach of Contract.** Providence and Imperial incorporate paragraphs 1-12 as if fully set forth herein. A valid, enforceable contract exists between Providence and Imperial, on the one hand, and Presidion, on the other. Providence and Imperial have performed and continue to perform their contractual obligations. Presidion has breached the contract by failing to pay the Incurred Amounts, state assessments, and premiums when due. Through March 31, 2007, Presidion owes in excess of \$103,436.88 to Providence and Imperial. Presidion's breach caused and continues to cause Providence and Imperial injury.

14. **Declaratory Judgment.** Providence and Imperial state that there is an actual, justiciable controversy between the parties and requests that the Court grant declaratory judgment relief pursuant to 28 U.S.C. § 2201 and adjudicate the following issues and declare the following:

- a. Presidion is required to pay the Incurred Amounts to Providence and Imperial as they are determined and invoiced; and

- b. Presidion is obligated to pay Providence and Imperial for the future state assessments.

15. **Attorneys' Fees.** Providence and Imperial seek to recover their reasonable and necessary attorneys' fees pursuant to 28 U.S.C. § 2201 and TEX. CIV. PRAC. & REM. CODE § 38.001, et seq.

**REQUEST FOR RELIEF**

16. **Prayer.** Providence and Imperial request the following relief:
  - a. That Presidion be served with the Complaint and Summons and be required to answer in the time and manner prescribed by law;
  - b. That, on final hearing, the Court enter final judgment in favor of Providence and Imperial against Presidion, and award all damages caused by Presidion, including attorneys' fees, costs of court, and pre-judgment and post-judgment interest at the highest lawful rate;
  - c. That, on final hearing, Providence and Imperial recover the declaratory relief requested above, and be awarded attorneys' fees and costs of court, and post-judgment interest on those amounts at the highest lawful rate; and
  - d. That Providence and Imperial have such further relief, both general and special, at law and in equity, to which it may be justly entitled.



# Department of Justice 14

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April 19, 2007

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## **FIVE INDICTED IN NATIONWIDE FRAUDULENT WORKERS' COMPENSATION INSURANCE SCHEME**

Jacksonville, Florida - Acting United States Attorney James R. Klindt, Michael J. Folmar, Special Agent in Charge, Federal Bureau of Investigation, Jacksonville Division, and Alex Sink, Chief Financial Officer for the State of Florida, today announced the unsealing of a 25-count indictment charging five defendants with conspiracy, wire fraud, mail fraud, and money laundering in relation to alleged massive workers' compensation insurance fraud. The defendants named in the indictment are: (1) Jerry M. Brewer, a 56-year-old resident of Capistrano Beach, California, currently residing in England; (2) Donald E. Touchet, a 53-year-old resident of El Cajon, California; (3) Dr. Richard E. Standridge, a 58-year-old resident of Tempe, Arizona; (4) Robert J. Jennings, a 59-year-old resident of Danville, Illinois; and (5) Joshua Poole, a 33-year-old resident of Atlanta, Georgia.

Brewer is named in each of the 25 counts and if convicted faces up to 275 years' imprisonment and a fine of up to \$8.9 million. Touchet is named in 22 counts and if convicted faces up to 215 years' imprisonment and a fine of up to \$7.9 million. Standridge is named in 11 counts and if convicted faces up to 100 years' imprisonment and a fine of up to \$1.25 million. Jennings is named in 15 counts and if convicted faces up to 165 years' imprisonment and a fine of up to \$2.2 million. And Poole is named in eight counts and if

convicted faces up to 100 years' imprisonment and a fine of up to \$2.5 million. **15**  
Additionally, a forfeiture allegation in the indictment seeks more than \$100 million in forfeiture, as proceeds of the fraudulent scheme.

According to the indictment, the defendants, along with others, conspired between 2001 and April 2004 to defraud client companies of professional employer organizations (PEOs), nationwide, into paying workers' compensation insurance premiums for fraudulent, illegal, and sham workers' compensation insurance coverage, leaving thousands of employees throughout the United States without workers' compensation insurance coverage. The indictment alleges that conspirators used corporate names of purported insurance companies and incorporate offshore foreign corporations to provide an air of legitimacy to their fraudulent scheme. As part of the scheme, it is alleged that conspirators, using co-conspirator insurance brokers and consultants, contracted with owners and operators of PEOs, to provide their client companies with sham workers' compensation insurance. It is further alleged that owners and operators of PEOs fraudulently represented to their client companies that the client companies' employees were legally and legitimately covered under the PEO's workers' compensation insurance policy, knowing that the alleged workers' compensation insurance company did not have the authority to transact business or provide insurance coverage. The indictment sets forth details surrounding domestic and international electronic transfers of millions of dollars of fraudulently obtained insurance premiums.

The case was investigated by the Federal Bureau of Investigation and the Florida Department of Financial Services, Fraud Division, and will be prosecuted by Assistant United States Attorney Mark B. Devereaux.

An indictment is merely a formal charge that a defendant has committed a violation of the federal criminal laws, and every defendant is presumed innocent until, and unless, proven guilty.

**Individuals Charged in Jacksonville, Florida, in the \$100 Million Scheme Involving Regency Insurance of the West Indies**

1. Jerry Brewer - charged - but not yet located - fugitive - believed to be in England - identified as one of the leaders of the scheme; indicted April 19, 2007;
2. Tom Brown - Orange, California - worked for Stat-Care; has pled guilty but has not yet been sentenced; testified against King; sentencing set for January 10, 2008;
3. Don Ciaccio - Kankakee, Illinois - officer and director of TTC Illinois; Criminal Information filed July 13, 2007; pled guilty September 6, 2007; sentencing set for December 6, 2007;
4. William Colton Coile - Fairhope, Alabama; president of Coile & Associates; charged in a Criminal Information on June 18, 2007; pled guilty on June 27, 2007;
5. Andy Dyndul - St. Petersburg, Florida - president of Pyramid Employer Services; pled guilty on June 21, 2007; sentencing set for November 15, 2007;
6. Robert Jennings - Danville, Illinois - president of Interstate Administrative Services, a claims payment company; indicted April 12, 2007; trial set for January 7, 2008;
7. Larry Jones - Tampa, Florida - president of MRIK, an employee leasing company; indicted August 9, 2007; trial set for November 5, 2007;
8. Tom King - Jacksonville, Florida - president of MiraLink, an employee leasing company; sentenced to 14 years;
9. Steve Landin\* - Vero Beach, Florida - registered agent for Coverlink, LLC; charged by Criminal Information on July 17, 2007; pled guilty on September 5, 2007; sentencing scheduled for December 6, 2007;
10. Mike McCafferty - Kankakee, Illinois - president of TTC Illinois; sentenced to 33 months; testified against King;
11. Josh Poole\* - Atlanta, Georgia - president of Horizons PEO; indicted April 17, 2007; trial set for January 7, 2008;
12. Edgar Rawls - Largo, Florida - president of Core Employer Services - Criminal Information filed 7/16/07; pled guilty 9/6/07; sentencing set for 12/6/07;
13. Dr. Richard Standridge - Tempe, Arizona - president of EOSHealth, a claims payment (third-party administration) company; indicted 4/17/07; trial set for 1/7/08.
14. Peter Thosteson - Dothan, Alabama - president of TMG Staffing Services; Criminal Information filed 7/13/07; pled guilty on 8/7/07; sentencing set for 10/31/07;
15. Don Touchet - also worked for Stat-Care in Orange, California with Tom Brown; charged in Florida and arrested in California; no plea to date; indicted 4/17/07; trial set for January 7, 2008.

United States District Court, W.D. North Carolina,  
Charlotte Division.  
**STRATEGIC OUTSOURCING, INC.**, Plaintiff,  
v.  
CONTINENTAL CASUALTY COMPANY, Defendant.  
No. 3:02cv540.

March 15, 2007.

ORDER  
ROBERT J. CONRAD, JR., Chief United States District Judge.

THIS MATTER is before the Court pursuant to motions by Continental Casualty Company ("CNA") (Doc. No. 163) and **Strategic Outsourcing, Inc.** ("SOI") (Doc. No. 166) for judgment as a matter of law, or, in the alternative, for a new trial, pursuant to Federal Rules of Civil Procedure 50 and 59. For the reasons discussed below, the Court will DENY both motions.

## I. BACKGROUND

In December 2002, SOI instituted this breach of contract action after attempts to negotiate a renewal of its workers' compensation insurance with CNA failed and SOI obtained a substitute policy from another carrier. SOI sought damages for the costs of obtaining the replacement insurance for the time that would have been covered by the agreement with CNA. The Court's resolution of cross-motions for summary judgment left two issues remaining for trial: whether CNA's decision to increase the insurance rates was objectively reasonable under the contract; and whether SOI had overpaid or underpaid CNA for premiums during their relationship. (Doc. No. 108: Memorandum and Order; Vol. I TR at 6). In March 2006, the Court conducted a six-day trial during which over 200 exhibits were admitted and nearly 20 witnesses testified live or by deposition. After the Court denied the parties' Rule 50 motions, the jury returned a verdict in favor of SOI for approximately \$10.5 million on the breach of contract claim and in favor of CNA for \$758,345 on the underpayment of premiums. (Doc. No. 151: Jury Verdict). The parties subsequently filed post-trial motions that are currently before the Court.

## II. TRIAL EVIDENCE

### A. Breach of Contract

The focus of the breach of contract claim was on a provision that read: Additional Locations Or Exposures May Make It Necessary To Re-evaluate Rates, Premiums and Plan Factors-If, In Our Opinion, Such Additional Exposures, Premiums Anticipated And Prior Losses Represent Significant Changes From What Has Been Contemplated Herein. (Pl.Ex. 18 at SOI 003735).<sup>FN1</sup> SOI presented evidence to show that its growth in payroll and locations had not increased CNA's "exposure" significantly from what had been contemplated by the parties. For instance, former SOI CEO Robert Fotsch testified that his company carefully screened its accounts to comply with CNA's rules regarding prohibited occupations and locations. (Vol. I TR at 105-111; Vol. II TR at 308-311).<sup>FN2</sup>

SOI Vice President of Risk Management William Michel testified that CNA never voiced objections to SOI's plans for growth in payroll and locations. (Vol. III TR at 790-791). Lisa Dennison, an expert in actuarial science, opined that SOI's mix of business had not become riskier and that there had not been a material shift among the states where SOI operated. (Vol. IV TR at 1004).

CNA countered that SOI's exponential payroll growth and expansion into high-risk states were sufficient to trigger its option to re-evaluate the rates. CNA underwriter Charles Kliche testified that SOI's program originally involved \$185 million in payroll with an expected premium of \$6.3 million, and an expected loss content of \$5 million.<sup>FN3</sup> (Vol. III TR at 932; Def. Exhibit 44). By December 1999, CNA expected \$440 million in payroll with an expected loss of \$15.5 million (Vol. III TR at 948; Def. Ex. 507). Charles Pearl, an expert in actuarial science, opined that anticipated premiums would have decreased relative to payroll because of two discount programs that had been added to SOI's account. (Vol. IV TR 1163-1165). CNA underwriter Jeffery Pfluger testified that the combination of the payroll growth, expansion of locations into high-risk states, and loss rates caused CNA to conclude the premium rate in the original agreement could no longer be justified. (Vol. V TR at 1521-1540).

FN3. Loss content is the amount of loss that can be sustained by the insurance company while still realizing a "reasonable" profit. (Charles Kliche, Vol. III TR at 932).

#### B. Underpayment/Overpayment of Premiums

CNA asserted a counterclaim that SOI had underpaid premiums during their relationship. CNA Manager of Billing Services Troy Garris testified that there were delays in determining SOI's premiums between 1997 and 2000 because SOI was late in providing payroll audits and subsequently revised those audits. (Vol. V TR at 1281-1282). For example, an audit that originally showed \$285 million of payroll in the base program was later reduced to \$238 million. (Vol. V TR at 1294). The change was attributable to SOI's reclassification of payroll into a discount program with lower rates. (Vol. V TR at 1294-1295). However, CNA provided evidence of an agreement that subjected SOI to a penalty for falling below \$250 million in payroll in the base program, which had higher rates. (Vol. V TR at 1295-1297; Pl.Ex. 230: Confirmation Letter at CNA 006542). After factoring overpayments and underpayments between 1996 and 2000, Mr. Garris concluded that SOI owed CNA \$602,142. (Def.Ex.519). SOI presented evidence that there was no agreement in 1999 that required a minimum payroll of \$250 million in the base program and that it had overpaid premiums during the relevant years. William Michel testified that he did not believe the contract changed in any way for the 1999 policy year. (Vol. II TR at 502). Former SOI CFO John Thigpen testified that he did not use a minimum payroll when determining premiums due for the 1999 policy year because he did not believe one applied. (Vol. V TR at 1361). Thus, following SOI's reclassification of payroll into the discount program, he concluded in August 2001 that CNA owed SOI \$48,019. (Vol. V TR at 1376-1377; Def. Ex. 339). Without taking into account premiums owed by SOI to CNA for policy years 1996 through 1998, SOI CFO Michael Willson determined that CNA owed SOI \$1,758, 465 for overpaid premiums. (Vol. VI TR at 1689, 1703).

### III. DISCUSSION

#### A. Legal Standard...

#### B. CNA's Motion (Doc. No. 163)

In its motion for judgment as a matter of law, or, in the alternative, for new trial, CNA essentially raises six issues: (1) the sufficiency of the evidence supporting the jury's verdict in favor of SOI on the breach of contract claim (Doc. No. 163: Motion at ¶¶ 7-15); (2) SOI's conduct during the trial (¶¶ 16-17); (3) the Court's discovery ruling regarding certain witnesses (¶ 18(a)); (4) the Court's refusal to limit damages to ninety days (¶ 18(b)); (5) the Court's exclusion of evidence relating to the extension agreement (¶ 18(c)); and (6) the inclusion of the discount "Admin" and "Solomon Restaurants" programs in the damages calculation (¶ 14).

##### 1. Sufficiency of the evidence

The parties agree that the contract gave CNA the right to re-evaluate the rates if, in its objectively reasonable opinion, additional locations or exposures, anticipated premiums, and prior losses represented significant changes from what had been contemplated. (Doc. No. 168: CNA Memorandum at 1-3; Doc. No. 192: SOI Resp. at 2). The evidence at trial showed that SOI expanded in locations and payroll during the years in question; however, it does not necessarily follow that CNA's actions were objectively reasonable (Rule 50) or that the jury's verdict was against the clear weight of the evidence (Rule 59). In light most favorable to SOI and without assessing the credibility of the witnesses, the evidence was sufficient to support the jury's conclusion that CNA was not objectively reasonable in deciding that the growth represented a significant change from what had been contemplated. Lisa Dennison examined SOI's growth in locations in seven states between 1998 and 2000 and determined there had not been a material shift between the states. (Vol. IV TR at 1012). Although SOI had a presence in high-risk states like Texas and California, the minuscule amount of payroll there rendered it statistically insignificant. (Vol. IV TR at 1013-1014). The state with the largest growth, Georgia, is not considered an expensive state for insurers. (Vol. IV TR at 1015). Ms. Dennison also evaluated SOI's book of business for that time period and found that its risk had declined. (Vol. IV TR at 1009-1010). \*4 Additionally, the jury's verdict was not against the clear weight of the evidence. CNA underwriter Tim Fenton, who was involved in the formation of the agreement in 1998, testified that growth in payroll and losses was expected. (Vol. II TR at 357). SOI CEO Robert Fotsch testified that in meetings CNA representatives John Glancy and Jaqueline Bomar never complained about SOI's growth in payroll or types of clients; only that CNA was losing money on the program. (Vol. I TR at 165-167). Even so, a memorandum written by Ms. Bomar in December 1999 noted that SOI had shifted its client base to lower hazard groups, invested time in loss control, and experienced significant decreases in loss rates. (Pl.Ex.43). Therefore, neither judgment as a matter of law in favor of CNA nor a new trial is warranted based on the sufficiency of evidence on the breach of contract claim.

##### 2. SOI's conduct in the trial

CNA argues it is entitled to a new trial to correct intentional misconduct by SOI counsel designed to confuse the jury. (Doc. No. 163: Motion at ¶¶ 16-17). The Court ruled prior

to trial that SOI would be prohibited from arguing that the contract called for a rate guaranteed for three years. (Doc. No. 132: Order at ¶ 5). CNA admits there is a meaningful difference between a “guaranteed three-year rate,” which implies one rate for three years, and a “three-year guaranteed rate program,” which implies a certain type of insurance where there is no element of self-insurance. (Doc. No. 168: CNA Memorandum at 29). CNA accuses SOI of intentionally misusing the legitimate contractual term “guaranteed rate” or “guaranteed cost” to imply the illegitimate position that the \$3.40 rate was guaranteed for three years. While CNA points to numerous examples in the testimony of Robert Fotsch that “repeatedly conflated guarantee and rate,” (Doc. No. 168: CNA Memorandum at 30-31), it waived this complaint by failing to object to any of the cited examples when the testimony was offered.<sup>FN4</sup> *United States v. Parodi*, 703 F.2d 768, 783 (4th Cir.1983). When CNA did object to similar testimony by William Hagar, the Court sustained the objection and instructed the jury to disregard that testimony. (Vol. IV TR at 1047). When SOI counsel Robert Elster asked questions of Jeffery Pfluger regarding “a rate for three years,” the Court sustained CNA's objections. (Vol. V TR at 1572-1573).

FN4. Similarly, CNA waived its objections to SOI's closing arguments by choosing not to object (Doc. No. 168: CNA Memorandum at 33-34). *Lifmann v. Carlson Companies, Inc.*, No. 88-3901, 867 F.2d 609, 1989 WL 5440, at \*3 (4th Cir. Jan. 11, 1989) (unpublished).

The Court instructed the jury at the conclusion of the case that SOI must prove by the preponderance of the evidence that CNA failed to act in an objectionably reasonable manner when invoking the additional locations or exposures clause. The parties have agreed, and the Court has found, that there was no three-year rate guarantee under the applicable contract, but rather a contract a contract [sic] at an agreed-upon rate, subject to CNA's right to review that rate pursuant to the clause I just read. Although there has been some mention of a three-year guaranteed rate, you are required to accept the party's [sic] agreement and the Court's ruling and disregard such language. \*5 (Vol. VI TR at 1904). A jury is presumed to follow a court's instructions. *Stamathis v. Flying J. Inc.*, 389 F.3d 429, 436 (4th Cir.2004) (citing *Richardson v. Marsh*, 481 U.S. 200, 211, 107 S.Ct. 1702, 95 L.Ed.2d 176 (1987) and *Nichols v. Ashland Hosp. Corp.*, 251 F.3d 496, 501 (4th Cir.2001)). The mere fact a jury finds against an objecting party is not evidence that it ignored a curative instruction. *Hinkle v. City of Clarksburg, W.Va.*, 81 F.3d 416, 426 (4th Cir.1996). Here, the Court was disappointed with SOI's counsels' intentional injection of the “three-year guaranteed rate” concept into the case after the Court clearly and repeatedly instructed counsel that it was not an issue. However, such misbehavior does not in itself justify a new trial. The Court specifically instructed the jury to disregard testimony and argument about a “three-year guaranteed rate.” As detailed above, the verdict was not against the clear weight of the evidence. The jury's verdict in favor of SOI on the breach of contract claim, but in favor of CNA on the counterclaim, shows that it was not confused by SOI's tactics, but rather conscientiously deliberated according to the Court's instructions. Thus, there was no cumulative effect from the misbehavior. CNA has failed to show that the jury ignored the Court's instruction or that a new trial is required to avoid a miscarriage of justice.

### 3. Discovery Ruling

CNA complains in its Motion that the Court erred as a matter of law by allowing SOI to call two witnesses who were not identified by SOI until shortly before the trial and were

not deposited by CNA. (Doc. No. 163: Motion at ¶ 18(a)).<sup>FN5</sup> SOI listed the two witnesses, Carl Guidice and Michael Willson, as persons with knowledge relevant to the case in its initial disclosures required by Fed.R.Civ.P. 26(a)(1). In accordance with the scheduling order, SOI listed Guidice as a witness expected to be called during trial and Willson to be called if the need arose pursuant to Rule 26(a)(3). At the pretrial conference, CNA argued that the parties had an agreement to disclose all trial witnesses in September 2005 so their depositions could be taken. SOI disputed the existence of such an agreement. Even so, CNA has established no prejudice from SOI's actions. Both witnesses were effectively cross-examined and SOI complied with Rule 26. Accordingly, a new trial is not required based on the Court's discovery ruling.

#### 4. Damages Period Ruling

CNA claims the Court erred in refusing to limit damages to ninety days following the breach, based on a cancellation provision in the contract.<sup>FN6</sup> (Doc. No. 163: Motion at ¶ 18(b)). CNA did not plead this defense in its Answer (Doc. No. 6), but rather raised the issue for the first time in its Statement of Disputed Issues for Trial (Doc. No. 116 at ¶ 5) and Trial Brief (Doc. No. 122 at 8). After hearing argument at the pretrial conference, the Court invited further briefing on the issue, which the parties provided on the first day of trial. (Doc. No. 138: SOI's Brief; Doc. No. 144: CNA's Brief). The Court ruled the following day that damages were not limited to the ninety-day period applicable to the cancellation clause. (Vol. II TR at 594-598).

FN6. That provision reads, in part:

We [CNA] may cancel this policy. If we cancel because you fail to pay all premium when due, we will mail or deliver to you not less than 10 days advance written notice stating when the cancellation is to take effect. If we cancel for any other reason, we will mail or deliver to you not less than 90 days advance written notice stating when the cancellation is to take effect. (Pl.Ex. 17 at BR 00005915).

<sup>\*6</sup> In making its decision, the Court primarily relied on...In *MCI Constructors*, the Fourth Circuit held that the general rule in North Carolina is that where a contract confers on one party a discretionary power affecting the rights of the other party, the contract is not illusory so long as the discretion is exercised in an objectively reasonable manner. 125 Fed. Appx. at 477. Thus, CNA's discretion to terminate the contract was limited by North Carolina's requirement of objective reasonableness, as was its decision to increase the renewal rates. The jury's determination that CNA was liable because its decision to increase the renewal rates was not objectively reasonable necessarily foreclosed CNA's exercise of the cancellation clause and the limitation of damages to the ninety-day period applicable to that clause. North Carolina law required CNA's decision to be objectively reasonable, whether it increased the renewal rates or terminated the agreement. Because the jury found CNA's decision was not objectively reasonable, the cancellation clause's ninety-day notice period could not have been triggered, and, thus, could not limit SOI's damages. Therefore, SOI was entitled to recover the costs for replacement insurance for the remainder of the agreement, and no miscarriage of justice occurred when the Court refused to limit the damages to the ninety-day period applicable to the cancellation clause.

imilarly, CNA presented evidence at trial that the parties continued to negotiate during their relationship about overpayment and underpayment based on payroll audits and revised audits, some of which were not finalized until years after the corresponding policy period ended. (Troy Garris, Vol. V TR at 1281). Former SOI CFO John Thigpen and current CFO Michael Willson each admitted that their goal was to resolve all the policy years together. (Vol. V TR at 1374; Vol. VI TR at 1694). In fact, Mr. Willson conceded that SOI owed CNA money for the years 1996 to 1998, but did not pay because the parties were attempting to reconcile all the policy years together. (Vol. VI at 1693-94). Mr. Garris, CNA's billing services manager responsible for the SOI account, testified that he expected SOI to pay until it filed its lawsuit. (Vol. V TR at 1299). Mr. Willson confirmed that he never communicated to CNA an intention not to pay for the previous years because it was too late.<sup>FN13</sup> (Vol. VI at 1694).

FN13. Thus, an instruction on the defense of laches was not warranted by the evidence. SOI showed no prejudice from delay that would make it inequitable or unjust for CNA to assert its claim for underpayment. *Young v. Young*, 259 S.E.2d 348, 351 (N.C.Ct.App.1979)(describing defense of laches).

The Court instructed the jury that the three-year limitations period would begin to run when either party gave clear and certain notice of its intention not to pay. (Vol. VI at 1908-1909). The jury returned a verdict for CNA regarding SOI's underpayment. (Doc. No. 151: Verdict at ¶ 3(b)). Viewing the evidence in light most favorable to CNA, the jury's implicit finding that CNA's counterclaim seeking damages for underpayments during the policy years between 1996 and 2000 (Doc. No. 6: Answer at 6) was filed within the limitations period after SOI gave clear notice of its intent not to pay and sought damages for overpayment with the filing of this action (Doc. No. 1: Complaint at ¶ 29) was reasonable and supported by sufficient evidence. Additionally, the verdict was not against the clear weight of the evidence, and did not result in a miscarriage of justice, particularly considering SOI's admission that it owed money to CNA, but did not pay as part of a process of on-going negotiations between the parties. Fed.R.Civ.P. 59.

## 2. Minimum Payroll for the Base Program

\*9 The jury awarded damages on the counterclaim in keeping with CNA's position that the base program for policy year 1999 was subject to a minimum payroll requirement. (*Compare* Doc. No. 151: Verdict at ¶ 3(b)(1) *with* Def. Ex. 519 *and* Troy Garris, Vol. V TR at 1296-1298). SOI disputes that sufficient evidence established a minimum payroll term in the 1999 agreement.<sup>FN14</sup> (Doc. No. 166: Motion at 6-10).

FN15. Thus, SOI's defense that it maintained a total payroll exceeding \$250 million in the three programs combined and in the base program over a fourteen-month period (Doc. No. 166: Motion at 8-10) is without merit. The testimony and documentary evidence regarding the minimum payroll term showed that it only applied to the base program with a \$3.40 rate over twelve months. SOI's argument (Doc. No. 194: Reply at 6) that a clause in the unsigned confirmation agreement referring to the adjustment of "all rates" as showing the inclusion of the discount programs (PI.Ex. 230 at CNA 006548) is contradicted by an earlier page in the document showing five rates for items such as administrative fee, claims service fee, and prepayment fund totaling \$3.40 (PI.Ex. 230 at CNA 006541). The next page notes these rates are subject to a minimum \$250 million payroll. (PI.Ex. 230 at CNA 006542). Therefore, the jury could reasonably conclude that

the “all rates” language referred to those comprising the base program total rate.

The risk became real in 2000 when SOI retroactively reclassified payroll from the base program into the discount program. (John Thigpen, Vol. V TR at 1364). The initial audit of \$285 million payroll in the base program was reduced to \$238 million in the final audit. (Troy Garris, Vol. V. TR at 1294; Def. Ex. 352). Because the base program was significantly more expensive,<sup>FN16</sup> the payroll shift to the discount program resulted in SOI owing \$1.4 million less in premium to CNA. (Troy Garris, Vol. V. TR at 1294; see also John Thigpen, Vol. V TR at 1365 (reclassification “probably” resulted in a \$900,000 reduction in premium)). Additionally, SOI did not provide quarterly audits as required. (Troy Garris, Vol. V. TR at 1344-1345, 1349).

FN16. The base program cost \$3.40 per \$100 of payroll, but the Soloman Restaurant program cost \$1.70 and the Admin program cost between \$0.40 and \$0.75 per \$100 of payroll.

In response, CNA accepted SOI's reclassification numbers, but calculated the premium due for the 1999 base program with a minimum payroll of \$250 million. (Troy Garris, Vol. V. TR at 1295-1296). Although SOI presented testimony from its officers that they did not think a minimum payroll term applied to the deal (William Michel, Vol. II TR at 502; John Thigpen, Vol. V TR at 1361), Mr. Garris testified that those same individuals did not protest his application of the term (Troy Garris, Vol. V. TR at 1350). Thus, substantial evidence supported the jury's verdict. Considering the weight of the evidence, the Court further finds that the jury's verdict was not against the clear weight of the evidence, was not based on false evidence, and did not result in a miscarriage of justice. Fed.R.Civ.P. 59. SOI received the benefit of reducing the premium by utilizing the discount programs, but remained obligated to the minimum payroll term applicable to the 1999 base program when its payroll fell below \$250 million and it did not provide timely audits. Accordingly, the Court will not disturb the jury's verdict in favor of CNA on the

#### 4. Future Damages

In its trial brief, SOI expanded on its request for “other and further relief” in its Complaint to seek a declaratory judgment that CNA was responsible to indemnify SOI for future additional costs associated with several open claims under the replacement Hartford insurance program. (Doc. No. 124 at 18-20). The Court denied SOI's request for declaratory judgment, but allowed SOI the opportunity to present evidence about the open claims to the jury. (Vol. IV TR at 1124-1125). In the instant motion to reconsider that ruling (Doc. No. 166: Motion at 14-16), SOI has largely restated its earlier argument with the addition of a citation to *ABT Building Products Corp. v. National Union Fire Insurance Co.*, No. 5:01cv100 (Doc. No. 204: Amended Judgment) (W.D.N.C. Sept. 30, 2004), *aff'd*, 472 F.3d 99, 2006 WL 3718088 (4th Cir. Dec. 19, 2006). (Doc. No. 194: Reply at 31). In that case, the jury returned a verdict finding that certain claims in a class-action lawsuit were covered by the insurance policy at issue.<sup>FN19</sup> (Doc. No. 194: Reply at Ex. C: Amended Judgment at 3). Based on that determination, the court ordered the defendant to pay the future costs of those claims for which the jury found it liable. (Doc. No. 194: Reply at Ex. C: Amended Judgment at 6).

FN19. The jury also made certain damages findings about those claims, such as amounts already paid on the claims, percentages of replacement and other costs, and

the defendant's liability for administrative costs per claim. (Doc. No. 194: Reply at Ex. C: Amended Judgment at 3-4).

**\*11** Here, SOI did not attempt to prove the particular open claims <sup>FN20</sup> nor did SOI seek a jury determination of CNA's liability for those alleged claims. (Doc. No. 121: Proposed Instructions; Doc. No. 149: Memorandum on jury instructions). Accordingly, this case is critically different from *ABT* because the jury did not find CNA liable for any open claims. If the Court were to impose such liability after SOI passed on its opportunity prove its case at trial, the Court would infringe on CNA's Seventh Amendment right to a jury's determination of whether the open claims were properly covered by the replacement Hartford insurance program. *Maher v. Continental Casualty Co.*, 76 F.3d 535, 541 n. 6 (4th Cir.1996) (insurer constitutionally entitled to jury trial where insured sought money damages). Therefore, the Court will not alter the judgment to declare CNA liable for the future costs of any open claims.

FN20. SOI Metrics Department Manager Erik Mikeal testified generally that open claims existed that could possibly generate additional costs to SOI. (Vol. III TR at 1087).

#### IV. CONCLUSION

**IT IS, THEREFORE, ORDERED** that CNA's Motion for Judgment as a Matter of Law or in the Alternative for a New Trial (Doc. No. 163) and SOI's Post-trial Motion (Doc. No. 166) are **DENIED**.



# U.S. Department of Labor

Employee Benefits  
Security Administration



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## MEWA Enforcement

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**U.S. Department of Labor**  
**Employee Benefits Security Administration**  
**July 2007**

### Background

Multiple Employer Welfare Arrangements (MEWAs) provide health and welfare benefits to employees of two or more unrelated employers who are not parties to bona fide collective bargaining agreements. In concept, MEWAs are designed to give small employers access to low cost health coverage on terms similar to those available to large employers. For certain employers they represent the only available option for providing employees with health care because insurance companies often will not insure small employers who do not fall within their desirable risk category.

Although MEWAs can be provided through legitimate organizations, they are sometimes marketed using attractive but actuarially unsound premium structures that generate large administrative fees for the promoters. In addition, certain promoters will set up arrangements that they claim are established pursuant to a collective bargaining agreement and, therefore, are not MEWAs but legitimate benefit plans free from state insurance regulations. Often, however, these collective bargaining agreements are nothing more than shams designed to avoid state insurance regulation.

States and the federal government coordinate the regulation of MEWAs pursuant to a 1982 amendment to the Employee Retirement Income Security Act (ERISA). This dual jurisdiction gives states primary responsibility for overseeing the financial soundness of MEWAs and the licensing of MEWA operators. The Department of Labor enforces the fiduciary provisions of ERISA against MEWA operators to the extent a MEWA is an ERISA plan or is holding plan assets. State insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they also are covered by ERISA.

### EBSA Enforcement Efforts

The Department has devoted significant resources to investigating and litigating issues connected with abusive MEWAs created by unscrupulous promoters who sell the promise of inexpensive health benefit insurance, but default on their obligations. Particular emphasis has been put on identifying ongoing abusive and fraudulent MEWAs, and working to shut down such operations.

### Enforcement Efforts To Date

To date, the Department has:

- Initiated 734 civil and 160 criminal investigations and obtained monetary results of over \$191 million. There are currently 88 civil and 40 criminal investigations open.
- Filed 84 civil complaints.
- Indicted 131 individuals with 95 convictions.
- Published technical assistance materials, including a booklet explaining federal and state regulation of MEWAs.

- Issued numerous advisory opinions to assist state prosecutors and regulators to enforce state insurance laws against MEWAs.
- Convicted individuals have been sentenced to total prison terms of approximately 272 years. Most of these investigations have been jointly investigated with other agencies, including the Department's Office of Labor Racketeering and Fraud Investigations, the FBI, the U.S. Postal Inspection Service, and the Internal Revenue Service's Criminal Investigative Division.

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## Recent Civil Litigation Cases

**Manufacturing and Industrial Workers Union (MIWU) Benefit Fund** – On March 28, 2007, the Department filed a complaint against Bryan, Texas-based Manufacturing and Industrial Workers Union Benefit Fund and against four trustees of the Paramount, California-based International Union of Public and Industrial Workers (IUPIW) Canadian Benefit Fund: William Hope, Gary Couch, Roger "Tim," Gue, and Robby Larkin; and Pamela Barlow, Secretary-Treasurer of the related IUPIW, for their role in causing the financial collapse and ultimate demise of the MIWU Fund in 2005. The action was filed in the U.S. District Court, Northern District of Georgia, Atlanta Division, in an effort to secure the MIWU Fund assets, protect the plan participants and halt alleged ongoing violations of federal law. The Department's suit alleged that the defendants mismanaged the Fund by admitting large groups of participants into uninsured medical plans without any underwriting and by failing to set contribution rates sufficient to fund the benefits offered in violation of ERISA. Further, the complaint alleged that the IUPIW Fund officials illegally transferred millions in unprocessed and unpaid claims from the IUPIW Canadian Benefit Fund in an effort to preserve IUPIW Canadian Benefit Fund solvency to the detriment of the MIWU Fund. The MIWU Fund allegedly owes more than \$4.8 million in unadjudicated and unpaid health care claims for approximately 2000 workers and their families in Georgia, Illinois, Texas, Arizona and other states. The lawsuit sought restoration of Fund losses, the appointment of an independent fiduciary and other equitable relief.

On May 11, 2007, the Department obtained a consent judgment appointing an independent fiduciary and barring the defendant from continuing to act in a fiduciary capacity with respect to any employee health benefit plan subject to ERISA, including the MIWU Fund. The independent fiduciary will terminate the MIWU Fund and collect, marshal, and administer any remaining assets, and will process and pay claims. Participants with health claims or questions should contact Betty Cordial, the independent fiduciary, at (602) 240-6821.

**Georgia Plumbers Trade Association for Continuing Education, Inc. (GPTA)** – On March 15, 2007, the Department filed a complaint in the U.S. District Court for the Northern District of Georgia, Atlanta Division, against Marc Meixner, Leslie E. Smith, David Sherman, GPTA Benefits Group, Inc. and Employers Onesource, Inc. The plan sponsor, Georgia Plumbers Trade Association for Continuing Education, Inc. (GPTA), located in Griffin, Georgia, is a non-profit organization established in 1994 to provide plumbers in the state of Georgia with education and resources to comply with changing plumbing codes.

The complaint alleges that the defendants mismanaged the GPTA Health Plan by paying illegal commissions and fees and by failing to pay plan benefits when due. As a result, \$646,875 in benefits has allegedly not been paid. The suit seeks a court order requiring that the defendants restore all plan losses with interest and return any illegal profits. The suit also seeks to permanently bar the defendants from serving any employee benefit plan governed by ERISA in the future and to appoint an independent fiduciary to manage the plan and its assets.

**Employers Resource Management, Inc** – On March 16, 2006, a final judgment and consent order was filed in *Chao v. Employers Resource Management Company, Inc. (ERM)*. ERM, headquartered in Boise, Idaho, sponsors a self-funded multiple employer welfare arrangement for small employers located in several states. The consent order requires that ERM maintain a minimum level of reserves for the payment of medical claims. ERM has contributed approximately \$588,000 to fund such a reserve pursuant to the agreement reached with the Department. ERM also agreed to hire qualified professionals to annually compute the amount the claims reserves must hold. The settlement also provides that ERM will forward employer and employee premiums to the health plan as soon as those monies can be segregated from its general assets, will separately hold in trust and account for the health plan's assets and will use the plan's assets only to pay proper claims and expenses. ERM also agreed to invest the plan's assets prudently and reimburse itself only for direct expenses in accordance with federal law.

**Solidarity of Labor Organization International Union (SOLO)** – On January 9, 2006, the District Court for the Southern District of New York entered a consent judgment specifically and permanently enjoining Anthony

Pecone from serving as a fiduciary or service provider of any employee benefit plan and from marketing or selling participation in employee benefit plans. Pecone's employer association, the National Entrepreneurs Association (NEA), required employers to pay a per capita fee to NEA for each of their employees in order to obtain coverage in the Solidarity of Labor Organization International Union Benefit Fund (Fund). Pecone's employer association allegedly diverted approximately \$1.3 million in plan assets in the form of employer association fees from employers seeking health benefits for their employees from the Fund. The Fund filed for bankruptcy in the United States Bankruptcy Court for the Southern District of New York and the Secretary's Consent Judgment acknowledged that the bankruptcy trustee of the Fund would continue to prosecute the claim of alleged diversion of plan assets against Mr. Pecone in the adversary complaint filed by the bankruptcy trustee.

**ePEO Link, Inc. and Integrated Professional Insurance Services, Inc. (IPIS)** – On December 1, 2005, the Department filed a complaint in the U.S. District Court, Northern District of Oklahoma, against ePEO Link, Inc. and Integrated Professional Insurance Services, Inc. (IPIS) charging those companies with violating ERISA in managing the ePEO Link Group Accident and Health ERISA Medical Care Plan, a multiple employer welfare arrangement (MEWA). Also named in the complaint were Roger Jeffrey, Jacqueline Holovka, and Frederick Roh, principals of ePEO Link, a Professional Employer Organization headquartered in Idaho, and Lon Olmstead, principal of IPIS, the MEWA's third-party administrator located in Bakersfield, California.

ePEO Link sponsored the MEWA from April 2001 through June 2003, at which time they terminated the MEWA leaving \$4.43 million in unpaid health claims. The complaint alleged that defendants ePEO Link, Jeffrey, Holovka, Roh, IPIS and Olmstead violated ERISA by, among other things, failing to ensure proper underwriting, contribution rates, and reserve levels, failing to obtain appropriate reinsurance, and failing to require that ePEO Link pay all amounts necessary to pay benefits. Defendant Olmstead also was charged with violating ERISA for receiving commissions from the MEWA's purchase of reinsurance contracts.

On June 19, 2006, the U.S. District Court for the Northern District of Oklahoma approved the consent order between the Department and ePEO Link, Inc., Integrated Professional Insurance Services, Inc. (IPIS), and the respective principals of those companies. The Consent Order permanently bars ePEO and its principals, Roger Jeffrey, Frederick Roh, and Jacqueline Holovka from serving as fiduciaries or service providers to ERISA plans. The Consent Order also permanently bars IPIS and its principal, Lon Olmstead, from serving as fiduciaries or service providers to ERISA Plans. The consent order is conditioned on each settling defendant adhering to the terms of a separate Class Action Settlement Agreement filed in the matter of EnviroSolve, LLC, et al v. ePEO Link, Inc. et al.

**International Union of Public and Industrial Workers (IUPIW) Canadian Benefit Fund** – On November 30, 2005, the Department filed a complaint against the International Union of Public and Industrial Workers (IUPIW) Canadian Benefit Fund (Fund) in the U.S. District Court, Northern District of Georgia (Atlanta Division). The complaint sought payment of over \$1.2 million in unpaid medical claims, as well as the appointment of an independent fiduciary to take over operation of the Fund. The suit also sought to bar the current Fund fiduciaries from further involvement with any plans covered by ERISA.

The defendants named in the complaint were the Fund and its fiduciaries, including its four trustees: William Hope (Hope), Gary Couch, Robby Larkin and Roger Gue, as well as Pamela Barlow, Secretary-Treasurer of the Petroleum Workers Union. The complaint alleges that the fiduciaries repeatedly admitted large groups of participants into the Fund's self-funded component even though they knew or had reason to know that many individuals in the groups had serious and/or chronic health conditions and, therefore, posed significant risks to the Fund's solvency. Since at least 2002, the Fund's fiduciaries imprudently failed to set contribution rates commensurate with the level of benefits offered and failed to perform any underwriting activities even when admitting large enrollee groups.

On March 21, 2007, the Department obtained a consent judgment shutting down the International Union of Public and Industrial Workers Canadian Benefit Fund. The judgment also restores \$542,727 to pay pending health claims of more than 2,000 workers and families, removes officials from their positions with the Fund, and appoints an independent fiduciary to manage the Fund's assets of \$762,606, terminate the plan and pay health claims. Plan officials must pay a civil monetary penalty and are permanently barred from service to any plan governed by the Employee Retirement Income Security Act in the future. Participants with health claims or questions should contact Betty Cordial, the independent fiduciary, at 602-240-6821.

**Riscomp Industries, Inc.** – On November 10, 2005, the Department filed a complaint in Minnesota U.S.

District Court against the executives of Riscomp Industries, Inc. for their imprudent management of the firm's health plan. The health plan was a multiple employer welfare arrangement (MEWA) that provided medical, dental, life and death benefits. The complaint alleges that Robert Wood, Kurt Wood, and David Nelson, who were trustees of the plan, violated ERISA by retaining more than \$1.2 million of health plan contributions from employers and employees in the firm's corporate account. When Riscomp filed for bankruptcy protection in November 2002, it left over \$2.1 million in unpaid claims.

On February 1, 2007, the Department obtained a consent judgment resolving the Department's complaint against Riscomp Industries, Inc., Robert Wood, Kurt Wood, David Nelson, and the RJ Associates Employee Benefit Plan and Trust. Under the Judgment, Riscomp, Robert Wood, Kurt Wood and David Nelson were required to pay \$512,313 to resolve the unpaid health claims of the MEWA, \$207,000 to an independent fiduciary to cover the costs of administering the claims payments, and \$102,463 in ERISA civil penalties.

**Professional Industrial & Trade Workers Union (PITWU)** – On April 28, 2005, the Department filed a complaint against the Professional Industrial & Trade Workers Union (PITWU) Health and Welfare Fund, Michael Garnett, James Doyle, Mark Maccariella, and Cynthia Holloway. The suit alleges that, while serving as fiduciaries with respect to the Fund, these individuals violated ERISA's exclusive purpose and prudent person provisions. The complaint further alleges that Doyle, Garnett and Macariella breached their fiduciary duties by diverting plan assets from the Fund in the form of commissions, union dues, administrative and billing fees, and other non-specified expenses. The complaint alleges that Holloway breached her fiduciary duties by failing to monitor the proper application of the Fund's assets by her three co-defendants as well as by David Weinstein, the Fund's architect. The complaint also seeks to have the defendants restore losses to the Fund, permanently enjoin the defendants from serving in the future as fiduciaries for ERISA-covered plans, and have the court appoint an independent fiduciary to administer the Fund.

**Midland Services, Inc.** – On January 5, 2005, the Department sued the president of the Nashville-based Midland Services, Inc. for misusing commissions and refunds owed to a health plan sponsored by the firm. Midland was an employee staff-leasing firm that operated a MEWA for employees leased to client employers.

The suit alleged that Midland and David Starkey violated ERISA when they received \$72,721 in illegal commissions and refunds of plan contributions, which were used for their personal benefit rather than to pay participant claims. The defendants allegedly selected a succession of service providers to insure the plan and provide administrative services between 1998 and 2002. In 1999 and 2001, two insurers defaulted on plan payment of claims. The plan provided health benefits to approximately 469 participants under a re-insurance arrangement. In 1999, Merrion Reinsurance Company, Ltd. failed to pay \$47,373 in benefit claims. North American Indemnity of Belgium also defaulted on \$223,000 in claims in 2001.

On April 20, 2005, a consent judgment was entered permanently barring David Starkey from service as a fiduciary, administrator, or service provider of future ERISA plans. Starkey is further barred from selling or marketing any health benefit arrangement not licensed in one of the 50 states.

**New Jersey Licensed Beverage Association** – On November 18, 2004, the Department sued the trustees, plan administrators, and other fiduciaries to the New Jersey Licensed Beverage Association health plan in Trenton, New Jersey, for mismanagement of the plan. The self-insured health plan left participants with more than \$6 million in unpaid health claims. The plan ceased operating in August 2003.

The lawsuit alleged that the defendants violated ERISA by failing to determine and maintain adequate funding levels to pay benefits from 1998 to 2003, and did not have adequate contribution rates to support benefit payments. The suit names as defendants the New Jersey Licensed Beverage Association, Inc., plan administrator Midlantic Healthcare, Inc., and numerous fiduciaries associated with the plan.

The suit alleged that Midlantic Healthcare, Inc. did not provide information to the plan trustees and fiduciaries regarding the financial condition of the plan, and did not manage the plan in a financially sound manner. The plan fiduciaries allegedly failed to remove Midlantic and its principal and did not properly monitor the actions of the plan administrator. In August of 2003, the plan had an unpaid claim backlog of \$6,220,323.

The New Jersey Licensed Beverage Association, Inc. sponsored the medical plan for as many as 3,895 employees who work in bars and restaurants throughout the state of New Jersey and elsewhere. The plan ceased operating in August 2003.

On January 5, 2006, Judge Joel A. Pisano for the United States District Court for the District of New Jersey entered a stipulation and order pursuant to the All Writs Act that stays all current federal and state court litigation and enjoins future suits against the plan, its participants, beneficiaries and fiduciaries for unpaid medical claims pending resolution of the Secretary's suit.

On March 30, 2007, the Department obtained a partial consent judgment ordering the fiduciaries to make restitution of \$1.5 million to the New Jersey Licensed Beverage Association Welfare Benefit Plan, less any applicable ERISA Section 502(1) penalties, and an additional \$150,000 for the court-appointed independent fiduciary to marshal the plan's assets, pay unpaid claims and terminate the plan. The judgment also enjoins each of the fiduciaries from serving as a fiduciary or service provider to any ERISA-covered plan based on their mismanagement of the plan. This judgment concludes the litigation and follows an earlier Partial Consent Judgment that was entered last month against Midlantic Healthcare, Inc., operated by co-defendant Stephan DiTomasso. The Midlantic Judgment provided for restitution of \$600,000.

**International Union of Industrial and Independent Workers Benefit Fund (IUIIW)** – On December 13, 2004, the Department entered into a consent judgment and order for payment of \$840,000 in restitution to the Paramount, California-based International Union of Industrial and Independent Workers Benefit Fund (Fund).

In September 2004, the Department had obtained a preliminary injunction removing the trustees and permanently barring them from service to the Fund. The order also terminated the Fund and appointed an independent fiduciary to manage the Fund's assets and to establish a claims procedure for participants.

On April 6, 2004, the Department filed a lawsuit against the purported union, former plan administrator Oak Tree Administrators, its owner Cherille Shelp and current and former trustees Geoffrey J. Beltz, James Miller, David Wright, and Henry Solowiej.

The Department's suit alleged that the purported union is a MEWA that marketed health benefits to employers in southern and western states. From July 2000 to June 2003, the defendants spent millions of dollars of fund assets on administrative expenses – including several hundred thousand dollars paid to the purported union and more than \$1 million to marketers of the arrangement. The Department also alleged that the defendants delayed processing health claims, failed to operate the fund in an actuarially sound manner and paid excessive fees for services provided to the fund.

On September 7, 2005, the Court determined that Cherille Shelp is a fiduciary to the Plan. On September 21, 2005, Ms. Shelp entered into a consent judgment permanently enjoining her from serving as an administrator, fiduciary, officer, trustee custodian, counsel, agent, employee or representative in any capacity to any ERISA-governed plan.

On November 17, 2005, former plan administrator Oak Tree Administrators entered into a consent order, which permanently enjoined and restrained Oak Tree Administrators from violating the provisions of Title I of ERISA and permanently enjoined it from providing third-party administrator services to any ERISA-governed employee benefit plan. Oak Tree Administrators agreed to entry of a judgment in the amount of \$1 million.

**Provider Medical Trust** – On January 30, 2004, the Department sued the fiduciaries of Provider Medical Trust (the Trust), a Tulsa-based MEWA for taking excessive fees and making misrepresentations that resulted in the participants incurring millions of dollars in medical bills while believing they had health plan coverage. Among the parties named in the lawsuit is Johnson Benefit Administrators, LLC, which controlled PMT and managed about 45 self-funded single employer group plans.

The suit sought the removal and a permanent bar of the plan fiduciaries from serving any employee benefit plan governed by ERISA, and asked that the fiduciaries provide an accounting of the excessive fee charges and make full restitution to the plans.

Since January 1, 1996, the defendants misrepresented the Trust's solvency and caused the Trust to pay excessive service fees to the plan administrator, which was owned by the fiduciaries. The fiduciaries also allegedly misrepresented the Trust's solvency to meet state insurance solvency requirements and continued to market the Trust without disclosing its true financial situation.

On August 15, 2005, the court ordered defendants Robert Johnson, Jr., and his corporate entities to restore \$4,900,000.00 in plan losses to the Provider Medical Trust. Judge Eagan also permanently barred Mr. Johnson

United States District Court,  
D. New Jersey.

**AJAX ENTERPRISES, Ajax Enterprises, Inc., Ajex Enterprises, Inc., Ujex Enterprises, Inc., Q-Town, Inc., Tjax Investment Corp., Plaintiffs,**

v.

Declan FAY, Industrial Insurance Agency, and John Does 1-100, Defendants,  
Declan Fay, Defendant/Third Party Plaintiff

v.

Insurance Agency, Cross Claim Defendant

Dale Fuller, Safety Alliance Group, and Industrial, Third Party Defendants.

Industrial Insurance Agency, Defendant/Third Party Plaintiff

v.

Declan Fay, Cross Claim Defendant

Dale Fuller, Safety Alliance Group, Robert Mitchell, Peo Solutions, and RKM Agency,  
Third Party Defendants.

Civil Action No. 04-4539 (NLH).

Aug. 31, 2007.

## **OPINION**

HILLMAN, District Judge.

### **I. INTRODUCTION**

\*1 In response to this Court's Order and Opinion denying plaintiff **Ajax Enterprises's** motion for summary judgment, plaintiffs sought and were granted leave to file an amended complaint. Defendant and third-party plaintiff, Declan Fay, filed a motion for summary judgment to dismiss the amended complaint, or in the alternative, for partial summary judgment, which was joined and supplemented by defendant Industrial Insurance Agency ("Industrial"). Plaintiffs **Ajax Enterprises, Ajax Enterprises, Inc. ("Ajax"),**<sup>FN1</sup> **Ajex Enterprises, Inc. ("Ajex"), Ujex Enterprises, Inc. ("Ujex"), Q-Town, Inc. ("Q-Town")** and **Tjax Investment Corp. ("Tjax")**(collectively, "plaintiffs") filed an opposition and cross motion for summary judgment.

FN1. Plaintiffs use the names **Ajax Enterprises** and **Ajax Enterprises, Inc.** interchangeably. They appear from the pleadings to be the same entity. They are referred to in this Opinion as "Ajax."

### **II. BACKGROUND**

Plaintiffs are professional employer organizations ("PEO's") that operate in the State of New Jersey.<sup>FN2</sup> A PEO contracts with small businesses to "hire" the employees of the small business with the intent that they become employees of the PEO, and then leases the employees back to the small business. This arrangement permits small businesses to pay less for workers' compensation insurance than if they tried to obtain it on their own. In addition to contracting with the PEO to provide workers' compensation insurance, the small business is relieved from having to perform the tasks of payroll, benefits, and unemployment insurance.

FN2. Ajax is incorporated in New Jersey; Ajex, Ujex and Tjax are incorporated in Delaware; and Q-Town is incorporated in Pennsylvania.

Plaintiffs are businesses owned and operated independently by Justin Sciarra. Mr. Sciarra is an attorney and held a New Jersey insurance producer license from 1979 until 1993. He testified that he had difficulty in late 2001 and in 2002 securing workers' compensation insurance for his PEO businesses and eventually contacted Todd Hammond, a professional acquaintance who owned a PEO, about coverage. Defendant Industrial, an Illinois corporation, was the insurer for Mr. Hammond's PEO. It appears that Mr. Hammond spoke with someone at Industrial who in turn contacted defendant Declan Fay, a resident of Illinois. Fay spoke with Mr. Sciarra about Ajax's workers' compensation needs. Fay had conversations with third party defendant, Dale Fuller about Ajax. Fuller had a relationship with third party defendant Safety Alliance Group ("Safety Alliance").<sup>FN3</sup>

FN3. It appears that Fuller owned PEO Solutions, LLC and obtained workers' compensation insurance from Safety Alliance.

On or about June 27, 2002, Fay contacted Mr. Sciarra and advised him that Safety Alliance would supply Ajax's workers' compensation coverage. On or about that same time, Ajax paid a \$30,000 referral fee to Industrial, and \$40,000 was wired to a bank account in the name of Safety Alliance. In July 2002, Mr. Sciarra flew to Chicago, Illinois for a lunch meeting with Fay, John Rodney and Mel Rodney (principals of Industrial), and Mr. Hammond. Plaintiffs allege that Fay and/or Industrial advised Ajax that Safety Alliance was part of a captive insurance program with St. Paul, Hartford and/or AIG "as the fronting insurance companies, and that the program was reinsured by 'A Paper' as defined by A.M. Best and Company."<sup>FN4</sup> Mr. Sciarra testified that Fay also told him that General Adjustment Bureau paid the claims. At this time, no certificate of insurance or policy was obtained by plaintiffs as proof of insurance with Safety Alliance.

FN4. Traditionally, a "captive" or "captive insurance company" is "an insurance company formed by a business owner to insure the risks of the operating business." Jay D. Adkisson, *Captive Insurance Companies*, xiii (2006). A captive "is licensed as an insurance company in the domicile where it is formed, foreign or domestic, and may later be licensed to conduct the business of insurance by other jurisdictions as well." *Id.* at 1. Its purpose is "to insure the risks of other companies that are also owned by the captive's owner, the parent" although a captive can underwrite risks unrelated to the captive's owners. *Id.* at 1, 29.

\*2 On or about February 2003, Ajax submitted its first workers' compensation claim to Safety Alliance which was denied as untimely. Mr. Sciarra states he became suspicious because he did not receive the customary reservation of rights letter from Safety Alliance as part of its denial of claim. He requested a certificate of insurance which was received on or after April 10, 2003 from Fuller. The certificate was faxed to Mr. Sciarra from Industrial. The Certificate provided that Safety Alliance Insurance Company was the insurer, Ajax was the insured, and RKM Agency and Associates was the insurance producer. The policy number listed on the certificate was 66-866-723AS/NJ. Mr. Sciarra testified in deposition that he also made several phone calls to various entities, including the General Adjustment Bureau, an unnamed attorney in New Mexico, the North Carolina Insurance Department, St. Paul Insurance Company, and Hartford insurance company. Based on the information he received, Mr. Sciarra believed that Safety Alliance did not exist. Accordingly, he initiated this action against defendants Fay and Industrial arguing that they breached their duty owed to plaintiffs and made material

misrepresentations. Plaintiffs allege that they have paid defendants more than \$157,151.00 in premiums for workers compensation insurance coverage. Fay brought a third party action against Dale Fuller and Safety Alliance.

### III. DISCUSSION

#### A. Summary Judgment Standard...

#### B. Defendants' Motion for Summary Judgment

\*3 In their amended complaint, plaintiffs allege that Fay was employed by or otherwise associated with Industrial, and Fay and/or Industrial were at all relevant times acting as plaintiffs' insurance agents. Defendant Fay filed a motion for summary judgment, joined by defendant Industrial, denying the allegations and moving to dismiss plaintiffs' amended complaint on the grounds that plaintiffs come into this Court with unclean hands, and, even if their claims are valid, they incurred no damages.

#### 1. Doctrine of Unclean Hands

Defendant Fay, joined by defendant Industrial, argues that plaintiffs' claims should be dismissed under the doctrine of unclean hands because they violated New Jersey law when they failed to obtain State approval to self-insure a portion of their workers' compensation obligation and when four of the plaintiffs failed to register with the Commissioner of the Department of Labor as employee leasing companies as required by State law.<sup>FN5</sup> Plaintiffs counter that defendants hands are unclean because, as licensed New Jersey brokers, they placed plaintiffs with a nonexistent carrier.<sup>FN6</sup>

FN5. Defendants state that prior to January 2003, none of the plaintiffs were registered as employee leasing companies with the New Jersey Commissioner of Labor in accordance with N.J.S.A. 34:8-70(10); in 2003, only Ajax was validly registered; none of the plaintiffs were registered in 2004; and in 2005, only Q-Town was properly registered with the Commissioner of Labor. In support of their statement, defendants attach correspondence from the New Jersey Department of Labor and Workforce Development, including copies of registration certificates for Q-Town and Ajax. In response, plaintiffs state that Ajax was registered as of 1996 and that "[a]ll of the other companies were combined under Ajax's registration because the owner of all the companies was the same." Plaintiffs submitted a letter from the State of New Jersey Department of Labor to "**Ajax Enterprises Inc.**" stating that its registration as an Employee Leasing Company was approved effective October 1, 1996.

It appears uncontested that **Ajax Enterprises, Inc.** was properly registered for the relevant time period in this litigation. Plaintiffs statement that all the other companies were combined under Ajax because the owner is the same is completely unsupported. The letter from the Department of Labor is addressed to **Ajax Enterprises** only, and plaintiffs have admitted that each PEO was operated separately. Also, Q-Town obtained a registration certificate independently in 2005. Thus, aside from Ajax, there is no evidence that any of the other plaintiffs were properly registered as PEO's in the State of New Jersey during the relevant time period.

FN6. We conclude in Section III.B.1 *infra* plaintiffs' assertion that Safety Alliance did not exist during the relevant time period is uncontested and therefore established.

What these arguments fail to address is that the doctrine of unclean hands is an equitable remedy... Accordingly, plaintiffs' legal claims are not barred as a matter of law by the equitable doctrine of unclean hands.

## 2. Premiums Paid by Plaintiffs

Defendants argue that plaintiffs have not incurred damages with regard to the premiums it paid to Safety Alliance. Fay states that the policy provides that Plaintiffs have a \$100,000 deductible per claim. Of those employees that have submitted claims, none of them amount to more than \$100,000. Fay argues that since plaintiffs have not yet met their deductible for any claim, Safety Alliance would not have been required to provide coverage yet on any of those claims and, therefore, plaintiffs have not incurred any damages. \*4 Plaintiffs do not dispute that the agreed upon deductible was \$100,000 and that they have paid less than that amount per claim. However, plaintiffs argue that "[t]here are claims outstanding, as well as currently unknown claims." Plaintiffs also argue that since the policy is nonexistent, so too then is the deductible. Even if no real policy exists, plaintiffs agreed upon a \$100,000 deductible and operated as if they were responsible for paying claims under that amount. *Cf. Diversified Packing and Development Corp. v. Dore & Assoc. Contracting, Inc.*, 48 Fed.Appx. 392, 399 (3d Cir.2002)(stating that damages should be designed to place the party in the same position it would have been if the contract had been performed). To the extent that plaintiffs seek as damages money they paid for claims that are within their agreed upon deductible amount, such request for relief is denied. For example, if plaintiffs paid \$40,000 in claims, plaintiffs are not entitled to include that amount in their damages. If plaintiffs paid \$140,000 directly to the claimant, then they would be able to claim \$40,000 as part of their damages. Although plaintiffs raise the possibility that the claims might continue to incur costs, and that unknown claims might arise, they provide no support for this assertion. *See Anderson*, 477 U.S. at 256-57 (concluding that the nonmoving party must identify specific facts and affirmative evidence that contradict those offered by the moving party to withstand summary judgment); *Saldana*, 260 F.3d at 232 (stating that a party opposing summary judgment must do more than just rest upon mere allegations, general denials, or vague statements). The purported coverage period with Safety Alliance was approximately 2002-2003. Plaintiff Ajax filed its original complaint on September 20, 2004. The statute of limitations for workers' compensation claims is two years. *See, e.g., Adams v. New York Giants*, 827 A.2d 299, 303 (N.J.Super.2003). It is seems unlikely that new, timely claims can be filed. Also, plaintiffs have not provided any evidence or facts that could support a finding that the existing claims will increase to more than \$100,000 each. Defendants have provided that the per claim amounts plaintiffs have paid thus far are: \$6,584.71, \$10,133.25 and \$60,387.41. Plaintiffs have not disputed these amounts and have not provided any facts that could show that these claims could increase to over \$100,000. Of the three claims, only the \$60,387.41 claim shows some potential of incurring costs beyond \$100,000. However, plaintiffs have not identified any specific facts about nature of the injury (i.e., is it severe and/or permanent) or the type of medical care being received by the employee that could allow a finding that the claim will increase beyond plaintiffs' deductible. All that plaintiffs provide is an ambiguous statement that claims are outstanding. Thus, even taking all reasonable inferences in favor of the plaintiffs, we find that plaintiffs have not alleged facts that if

proven could allow a jury to conclude that they will incur costs beyond their deductible.

### 3. Payments Made to Safety Alliance

Defendants also seek to have plaintiffs' claim for damages seeking reimbursement of the premiums plaintiffs paid to Safety Alliance dismissed. Defendants argue that the money plaintiffs used to pay the premiums to Safety Alliance was collected by plaintiffs directly from their clients and, therefore, plaintiffs have suffered no discernable loss. Also, that the amount paid in premiums was a cost of doing business and if plaintiffs did not pay Safety Alliance, they would have had to pay another insurance carrier. Plaintiffs counter that part of the business of running a PEO is to collect fees from clients. Decisions on how to use that money, including to pay premiums, are part of their business. The fees collected are not earmarked for premiums nor are plaintiffs obligated to use particular fees to pay particular premiums. We agree that the amount of premiums that plaintiffs paid to a nonexistent insurance company represents a discernable and recoverable loss. How plaintiffs choose to collect their fees and what or how they choose to spend their revenue, assuming all choices comport with existing law, is left up to their business judgment. However, plaintiffs are running a PEO which statutorily requires that they maintain workers' compensation coverage. Plaintiffs must pay premiums to operate their businesses. Plaintiffs could not, under New Jersey law, operate as they suggest and, "simply ... [keep] all of its clients' funds (i.e., including the monies designated for Workers Compensation premiums) and earn[ ] profits equaling the monies paid to Defendants for fraudulent insurance coverage." New Jersey workers' compensation law requires that every employer insure its potential workers' compensation liability with an authorized insurance company, or comply with the strict statutory self-insurance requirements. See N.J.S.A. 34:15-71; N.J.S.A. 34:15-77; *Romanny v. Stanley Baldino Construction Co.*, 667 A.2d 349, 351 (N.J.1995)(finding that an employer that fails to obtain workers compensation insurance or comply with self-insurance requirements commits a crime of the fourth degree). Recognizing that plaintiffs must pay premiums in order to operate a PEO that is not self-funded, defendants suggest that the formula for damages in this situation is to take the amount of premiums that plaintiffs paid to Safety Alliance, \$162,340.94, compare that figure with the cost of premiums they would have had to pay to another insurance company, and subtract the difference. The damages would be the difference between what plaintiffs paid and what they would have had to pay in presumably higher premiums. In support of their theory, defendants rely on a New Jersey appellate case holding that the trial court should have deducted labor costs not expended in the calculation of damages. *Paris of Wayne, Inc. v. Richard A. Hajjar Agency*, 416 A.2d 436 (N.J.Super.1980). Defendants also rely on cases pertaining to the issue of calculation of lost profits. See *Deaktor v. Fox Grocery Co.*, 475 F.2d 1112, 1116 (3d Cir.1973); *Bell Atlantic Network Services, Inc. v. P.M. Video Corp.*, 730 A.2d 406 (N.J.Super.1999); *Borough of Fort Lee V. Banque National de Paris*, 710 A.2d 1 (N.J. Super 1998). \*6 Although we agree that paying premiums, if plaintiffs are not self-insured, is a cost of doing business, this is not a "lost profits" case. Plaintiffs are alleging that because of defendants' negligent misrepresentations, they paid premiums for workers' compensation coverage to a company that did not exist. If Safety Alliance did not exist, as we conclude it did not below, then someone or something received the payments without providing coverage.<sup>FN7</sup> Plaintiffs have provided that they paid \$162,340.94 in premiums to Safety Alliance. We cannot say as a matter of law that plaintiffs' damages with regard to the premiums it paid are so speculative to warrant dismissal on summary judgment. On the contrary, the claim appears to be on solid footing.

FN7. We do not conclude as a matter of law whether defendants acted as brokers because genuine issues of fact remain on this issue. See III.C.2. *infra*. If, however, plaintiffs are able to prove that defendants acted as brokers and had a duty to investigate Safety Alliance so that defendants stand in the shoes of the nonexistent insurance company, then they may be liable for the premiums paid.

### **B. Plaintiffs' Cross Motion for Summary Judgment**

Plaintiffs raise additional arguments in their opposition which they style as a cross motion. Plaintiffs argue that Safety Alliance did not exist and that they are entitled to summary judgment on their claim of breach of duty. Although seemingly part of their cross motion, plaintiffs ask the Court to make a determination that Safety Alliance did not exist. We address this issue first.

#### **1. Safety Alliance**

In our earlier opinion, the Court found that although plaintiffs provided persuasive evidence, they had not shown as a matter of law that Safety Alliance did not exist. In their cross motion, plaintiffs reargue their position that Safety Alliance does not exist and in support submit the Affidavit of Margaret Shaw, insurance examiner for the State of New Jersey. Ms. Shaw states in her affidavit that she conducted several searches in the producer licensing data base for Safety Alliance for the period January 1, 2002 through December 31, 2003, and found no match. Defendants have provided no argument or evidence to the contrary. Thus, based on the unopposed evidence submitted by the plaintiffs, we find that no reasonable jury could conclude that Safety Alliance existed during the time relevant to this litigation. See *Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 468 (1992) (finding plaintiff's theory economically senseless so that no reasonable jury could find in plaintiff's favor).

#### **2. Breach of Duty**

Plaintiff Ajax argued in its first motion for summary judgment that defendants breached their duty owed to plaintiff. The Court found that plaintiff had not met its burden to prove as a matter of law that defendants acted as brokers and denied the motion. Plaintiffs raise the same argument in their cross motion and in addition provide the report of JoAnn M. Ralph. Ms. Ralph opines that Declan Fay acted as a broker for Ajax for coverage placed through Safety Alliance, effective June 30, 2002, and for replacement coverage effective January 2003, and that Industrial acted as a broker for coverage placed through Safety Alliance effective June 30, 2002. In response, defendant Fay submits the report of John T. Klagholz who opines that Fay did not act as an insurance agent for plaintiffs, and that industry practice does not obligate Fay to have affirmatively investigated the viability of Safety Alliance. Klagholz offers the theory that Ajax intentionally did not procure workers' compensation insurance available through the New Jersey Workers Compensation Assigned Risk Plan ("Risk Plan"), and instead self-funded workers' compensation benefits without proper authorization <sup>FN8</sup> and charged its clients an inflated premium to turn a profit. Klagholz states that since plaintiffs' principal, Justin Sciarra, an attorney and former insurance agent, decided to forgo the Risk Plan, he had an obligation to investigate Safety Alliance and not rely on just certificates of insurance rather than evidence of an insurance policy. ..

In addition, Industrial submitted the report of Martin A. Lebson, who echoes the theory that plaintiffs' principal, Justin Sciarra, was a sophisticated buyer in the insurance

industry and orchestrated his own scheme for workers' compensation coverage. More particularly, Industrial maintains that it did not act as a broker and that plaintiffs had already made the decision to go with Safety Alliance before Sciarra met with anyone from Industrial. Although we have the benefit of the reports of Ms. Ralph, Mr. Klagholz and Mr. Lebson since our last opinion, the underlying facts have not changed regarding the alleged duties of defendants. No additional facts have been presented by plaintiffs that could allow us to rule as a matter of law that defendants acted as brokers or agents. Plaintiffs' arguments regarding the duty of a broker in investigating the viability of an insurance company rests on the assumption that defendants acted as brokers. Plaintiffs have not proven there is no genuine issue as to material fact on this issue that would entitle them to judgment as a matter of law. For the reasons expressed in this Court's earlier opinion that reasonable minds could differ on the issue of whether defendants acted as brokers, we deny summary judgment...

#### **IV. CONCLUSION**

For the foregoing reasons, we deny in part and grant in part defendants' motion for summary judgment, and deny in part and grant in part plaintiffs' cross motion for summary judgment. Defendants' motion to dismiss plaintiffs' claims under the doctrine of unclean hands is denied; defendants' motion to dismiss plaintiffs' claims for damages regarding payments made to claimants under the \$100,000 deductible is granted; and defendants' motion to dismiss plaintiffs' claim for damages regarding the premiums it made is denied. Plaintiffs' motion for summary judgment that defendants breached their duty is denied; and plaintiffs' request for a ruling that Safety Alliance did not exist at the relevant times herein is granted. Since there is no prevailing party as a result of this Opinion deciding the motions for summary judgment, we do not reach the merits of whether plaintiff is entitled to attorneys' fees.

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA

Case No. 05-60212-CR- JORDAN/KLEIN(S)

18 U.S.C. 1343  
18 U.S.C. 1346  
18 U.S.C. 1349  
18 U.S.C. 1621  
18 U.S.C. 1952

UNITED STATES OF AMERICA, )  
)  
)  
)  
vs. )  
)  
)  
JOSE DAVID KAUFMAN, )  
OTHA RAY MCCARTHA, and )  
CHARLES J. SPINELLI, )  
)  
Defendants. )  
\_\_\_\_\_ )

FILED by *LM* D.C.  
MAG. SEC.  
MAR 14 2006  
CLARENCE MADDOX  
CLERK U.S. DIST. CT.  
S.D. OF FLA. FT. LAUD.

SUPERSEDING INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At times material to this Indictment:

1. Strategic Bancorp, LLC ("Strategic"), was the name of a business registered in the State of California by William Leyton ("Leyton"), who held himself out as president of Strategic.
2. Certified Services, Inc. ("Certified"), was a duly formed corporation, registered in the State of Nevada. Its principal office was located in Fort Lauderdale, Florida. Certified's common

*Handwritten signature/initials*

stock was registered with the Securities and Exchange Commission and was publicly traded on the Over-the-Counter ("OTC") Bulletin Board. Certified was a holding company, which owned several subsidiary companies.

3. The Cura Group, Inc. ("Cura") was a duly formed corporation, registered in the State of Florida, which had its principal office in Fort Lauderdale, Florida. Cura was one of the subsidiary companies owned by Certified and was engaged in the professional employer organization ("PEO") industry.

4. Midwest Merger Management, LLC ("Midwest"), was a duly formed limited liability company, registered in the state of Kentucky. Midwest purported to be in the business of risk management.

5. Brentwood Capital Corporation ("Brentwood") was a duly formed corporation, registered in the state of New York. Brentwood purportedly provided advisory services to businesses.

6. CNA Financial Corp. ("CNA") was a duly formed corporation, registered in the state of Delaware, with its headquarters located in Chicago, Illinois. Among other services, CNA provided various forms of insurance to businesses, including worker's compensation insurance, through insurance companies that it owned. Such insurance companies included Continental Casualty Company; National Fire Insurance Company of Hartford; American Casualty Company of Reading, Pennsylvania; and Transcontinental Insurance Company.

7. Presidion Solutions, Inc. ("Presidion"), was a duly formed corporation, registered in the state of Florida, with a business office in North Miami Beach, Florida. Presidion was engaged in the PEO industry.

8. First Commercial Insurance Company ("First Commercial"), was a privately owned

insurance company, duly licensed in the state of Florida, with its headquarters in Miami Lakes, Florida. Among other insurance products, First Commercial provided worker's compensation insurance to businesses such as Presidion.

9. Lumbermen's Underwriting Alliance ("Lumbermen's") was a privately owned insurance company, duly licensed in the state of Florida, with its headquarters in Boca Raton, Florida. Among other insurance products, Lumberman's provided worker's compensation insurance to businesses such as Presidion.

10. Defendant JOSE DAVID KAUFMAN was a friend and business associate of William Leyton.

11. Defendant OTHA RAY MCCARTHA was a director of Certified and also the Chief Risk Officer for Cura. MCCARTHA also worked as a consultant for Midwest and as a consultant and vice president of Brentwood.

12. Defendant CHARLES J. SPINELLI was the president and CEO of Brentwood.

### COUNT I

### CONSPIRACY

13. Paragraphs 1 through 12 are realleged and incorporated by reference as if fully set forth herein.

14. From in or about June 2002, through in or about April 2005, in Palm Beach, Miami-Dade and Broward Counties in the Southern District of Florida, and elsewhere, the defendants,

**JOSE DAVID KAUFMAN,  
OTHA RAY MCCARTHA, and  
CHARLES J. SPINELLI,**

did knowingly and willfully combine, conspire, confederate and agree with William Leyton, and with others known and unknown to the grand jury, to devise a scheme and artifice to defraud and to obtain money and property by means of materially false and fraudulent pretenses, representations and promises, and, for the purpose of executing the scheme, to transmit and cause to be transmitted by means of wire and radio communication in interstate commerce, certain writings, signs, signals, pictures and sounds, in violation of Title 18, United States Code, Sections 1343 and 2.

#### **PURPOSE AND OBJECT OF THE CONSPIRACY**

15. It was the purpose and object of the conspiracy that the defendants and others would unjustly enrich themselves by creating and furnishing to others documents purportedly issued by banking and financial institutions, knowing these documents were false and falsely reflected available assets.

#### **MANNER AND MEANS OF THE CONSPIRACY**

The manner and means by which the defendants and others sought to accomplish the object of the conspiracy includes, but is not limited to, the following:

16. William Leyton ("Leyton") represented to others that his company, Strategic Bancorp, LLC, was a business management firm able to procure financing and other services for client companies. Leyton offered to supply companies with "credit enhancements," that is, documents that would (falsely) show that a company had particular assets or available cash - thereby demonstrating creditworthiness in connection with other business activities of the company.

17. Leyton agreed to provide to defendants OTHA RAY MCCARTHA and CHARLES J. SPINELLI bank statements purporting to show that Brentwood Capital had \$5 million in unencumbered cash in a Bank of America bank account. Defendants OTHA RAY MCCARTHA

and CHARLES J. SPINELLI intended to use the fictitious and misleading bank statements in connection with the attempted purchase of an insurance company.

18. Leyton agreed with CHARLES J. SPINELLI to provide documentation that falsely showed that the (fictitious) \$5 million asset stemmed from a business deal between Strategic and Brentwood.

19. Leyton agreed to provide to defendants OTHA RAY MCCARTHA and CHARLES J. SPINELLI, acting as agents and/or employees of Certified Services/Cura, letters of credit purportedly issued by banking institutions, to be used as collateral or security to enable Certified Services/Cura to maintain worker's compensation coverage with CNA.

20. Leyton ultimately provided approximately eighteen (18) fraudulent letters of credit to CNA, on behalf of Certified/Cura, purportedly issued by the United California Bank and the Bank of the West, with a total face amount of approximately \$49,770,000.

21. Brentwood and Midwest received funds from Certified/Cura, from which defendants OTHA RAY MCCARTHA and CHARLES J. SPINELLI paid Leyton approximately \$2 million for the fraudulent letters of credit.

22. Brentwood, through defendants OTHA RAY MCCARTHA and CHARLES J. SPINELLI, entered into an agreement with Presidion to furnish letters of credit purportedly issued by banking institutions, to be used as collateral or security to enable Presidion to maintain worker's compensation coverage with Lumbermen's and First Commercial.

23. William Leyton furnished two (2) fraudulent letters of credit, purportedly issued by Bank of the West, at a face value of \$5.7 million to Brentwood and/or Presidion.

24. Defendant OTHA RAY MCCARTHA arranged with Leyton to provide approximately

eight (8) additional letters of credit, with a total face value of \$33,473,000, for the benefit of Presidion.

25. Defendant OTHA RAY MCCARTHA utilized a bank account in the name of Town Center Real Estate, d/b/a PDR Consulting Co., to receive payments from Presidion for eight (8) fraudulent letters of credit.

26. Defendant OTHA RAY MCCARTHA received approximately \$2.1 million from Presidion in payment for the fraudulent letters of credit, from which he paid Leyton approximately \$895,000.

27. Defendant JOSE DAVID KAUFMAN agreed to pose as a Senior Vice President of the United California Bank and the Bank of the West and to falsely attest to the legitimacy of the letters of credit, if and when any inquiries were made.

28. Defendant JOSE DAVID KAUFMAN affixed his signature to one of the fraudulent letters of credit, falsely representing himself to be a Senior Vice President of the United California Bank.

29. Defendant JOSE DAVID KAUFMAN agreed to pose as a Senior Vice President of the Bank of America, in connection with a fraudulent letter purportedly written on Bank of America letterhead to the Utah Department of Insurance.

30. Defendant JOSE DAVID KAUFMAN received compensation from Leyton in the approximate amount of \$100,000, plus other benefits, in exchange for his participation in the scheme.

31. The defendants intended to use and did use wire communications in interstate commerce, that is, interstate telephone and facsimile (fax) communications in furtherance of the scheme.

32. As a result of the actions of the defendants and others, CNA, First Commercial and Lumberman's provided worker's compensation insurance and paid claims that were supposed to be secured by letters of credit, resulting in financial losses and future risk of loss to the insurance companies exceeding \$50 million.

All in violation of Title 18, United States Code, Section 1349.

**COUNTS 2 - 12**  
(Wire fraud)

33. The allegations in paragraphs 1 through 12 are realleged and incorporated by reference as though fully set forth herein.

34. From in or about June 2002, through in or about April 2005, in Palm Beach, Miami-Dade and Broward Counties in the Southern District of Florida, and elsewhere, the defendants,

**JOSE DAVID KAUFMAN and  
OTHA RAY MCCARTHA,**

did knowingly and willfully devise and aid and abet in a scheme and artifice to defraud and to deprive others of the intangible right of honest services, and to obtain money and property by means of materially false and fraudulent pretenses, representations and promises.

**OBJECT OF SCHEME TO DEFRAUD**

35. The object of the scheme to defraud was that the defendants and others would unjustly enrich themselves by creating and furnishing to others documents purportedly issued by banking and financial institutions, knowing these documents were false and falsely reflected available assets.

**MANNER AND MEANS OF SCHEME TO DEFRAUD**

36. Paragraphs 16 through 32 above are incorporated by reference herein as setting forth the

manner and means of the scheme to defraud.

37. As a corporate officer, director and employee of Certified/Cura and as an agent, employee and consultant of Brentwood, defendant OTHA RAY MCCARTHA had a legal duty to act honestly and faithfully with Certified/Cura and Brentwood and to transact business in the best interest of Certified/Cura and Brentwood.

38. Defendant OTHA RAY MCCARTHA deprived Certified Services, Cura and Brentwood of the right to the honest services of their employees and agents by soliciting and receiving undisclosed payments or "kickbacks" from William Leyton in connection with the fictitious letters of credit that were issued on behalf of Certified/Cura.

39. Defendant OTHA RAY MCCARTHA contracted with Presidion to become an agent, consultant and broker of Presidion in procuring letters of credit for Presidion. As such, defendant OTHA RAY MCCARTHA had a legal duty to act honestly and faithfully with Presidion and to transact business in the best interest of Presidion.

40. Defendant OTHA RAY MCCARTHA deprived Presidion of the right to the honest services of its agents, consultants and brokers by failing to disclose that he was keeping and retaining for his personal benefit a substantial portion of the payments that were made by Presidion for the letters of credit.

41. Defendant OTHA RAY MCCARTHA deprived Brentwood of its right to the honest services of its employees and agents by diverting Presidion's business with Brentwood to himself and by soliciting and received undisclosed payments from Presidion.

#### **WIRE FRAUD**

42. On or about the dates specified as to each count below, for the purpose of executing the scheme and artifice to defraud and to deprive others of the intangible right of honest services, and

for obtaining money and property by means of materially false and fraudulent pretenses, representations and promises, the defendants, as enumerated as to each count below, did knowingly and willfully transmit and cause to be transmitted, by means of wire and radio communication in interstate and foreign commerce, certain writings, signs, signals, pictures and sounds, as more particularly described in each count below:

Count	Date	Defendant	Wire Communication
2	6/26/02	OTHA RAY MCCARTHA	Fax from OTHA RAY MCCARTHA in New York, New York, to Cura in Fort Lauderdale, Florida, discussing changes in the name of the account parties on a letter of credit in a amount of \$2,600,000.
3	9/09/02	OTHA RAY MCCARTHA	Fax from OTHA RAY MCCARTHA in New York, New York, to Cura in Fort Lauderdale, Florida, attaching a (fictitious) letter of credit in the amount of \$1,530,000.
4	10/22/02	OTHA RAY MCCARTHA	Fax from Brentwood, New York, NY to Lumberman's Underwriting Alliance, Boca Raton, FL.
5	11/07/02	OTHA RAY MCCARTHA	Fax from OTHA RAY MCCARTHA in New York, New York, to Cura in Fort Lauderdale, Florida, attaching a (fictitious) letter of credit in the amount of \$1,530,000.
6	1/03/03	OTHA RAY MCCARTHA	Fax from OTHA RAY MCCARTHA in New York, New York, to Cura in Fort Lauderdale, Florida, attaching a (fictitious) letter of credit in the amount of \$2,000,000.
7	3/14/03	JOSE DAVID KAUFMAN	Telephone call from Los Angeles, California, to Lumberman's Underwriting Alliance, Boca Raton, Florida.
8	3/17/03	OTHA RAY MCCARTHA	Fax from Fort Lauderdale, Florida, to Los Angeles, California.
9	3/18/03	JOSE DAVID KAUFMAN	Fax from Lumberman's Underwriting Alliance, Boca Raton, Florida, to Joe Kaufman, Los Angeles, California.

10	7/02/03	JOSE DAVID KAUFMAN	Telephone call from Los Angeles, California to First Commercial Insurance Co., Delray Beach, Florida.
11	9/03/03	OTHA RAY MCCARTHA	Fax from Fort Lauderdale, Florida to Louisville, Kentucky.
12	9/15/03	JOSE DAVID KAUFMAN	Telephone call from Los Angeles, California to First Commercial Insurance Co., Delray Beach, Florida.

All in violation of Title 18, United States Code, Sections 1343, 1346 and 2.

### COUNT 13

44. The allegations in paragraphs 1 through 12 are realleged and incorporated by reference as though fully set forth herein.

45. From in or about December 2002, through in or about September 2003, in Miami-Dade, Palm Beach and Broward Counties in the Southern District of Florida, and elsewhere, the defendant,

#### **OTHA RAY MCCARTHA,**

did knowingly and unlawfully use a facility in interstate commerce, that is, interstate commercial mail carriers and interstate telecommunications devices, in order to promote and carry on, and facilitate the promotion and carrying on, of an unlawful activity, to wit: commercial bribery, in violation of the laws of the State of Florida (F.S. 838.15), in that the defendant did solicit, accept and agree to accept benefits from William Leyton with the intent to violate his common law duties as an agent, employee and consultant of Brentwood Capital Corp, and as an officer, director, agent and employee of Certified Services, Inc. and The Cura Group, Inc.

All in violation of Title 18, United States Code, Section 1952.

### COUNT 14

46. The allegations in paragraphs 1 through 12 are realleged and incorporated by reference

as though fully set forth herein.

47. From in or about March 2003, through in or about June 2004, in Miami- Dade, Palm Beach and Broward Counties in the Southern District of Florida, and elsewhere, the defendant,

**OTHA RAY MCCARTHA,**

did knowingly and unlawfully use a facility in interstate commerce, that is, interstate commercial mail carriers and interstate telecommunications devices, in order to promote and carry on, and facilitate the promotion and carrying on, of an unlawful activity, to wit: commercial bribery, in violation of the laws of the state of Florida (F.S. 838.15), in that the defendant did solicit, accept and agree to accept benefits from Presidion Solutions, Inc., with the intent to violate his common law duties as an agent, broker and consultant of Presidion Solutions, Inc., and as an agent, employee and consultant of Brentwood Capital Corp.

All in violation of Title 18, United States Code, Section 1952.

**COUNT 15**

48. On or about November 12, 2004, in Miami-Dade County, in the Southern District of Florida, the defendant,

**OTHA RAY MCCARTHA,**

having duly taken an oath before Walter Mathews, a competent officer of the Securities and Exchange Commission, during an investigation duly authorized by the Commission, a case in which Title 15, U.S.C., Section 78u(b) authorizes an oath to be administered, and having sworn that he would testify truthfully, did willfully and knowingly and contrary to said oath state material matter which he did not believe to be true, that is to say:

48. At the time and place stated in paragraph 47, above, the Commission was conducting an investigation into the practices and financial condition of Certified Services, Inc., to determine

whether said corporation had violated certain provisions of the federal securities laws. It was material to the aforesaid investigation to determine what compensation OTHA RAY MCCARTHA had received from Certified Services, Inc. or from any other source since 2002.

49. At the time and place set forth above, OTHA RAY MCCARTHA appeared as a witness before the Commission, and then and there being under oath, testified falsely before the Commission with respect to the aforesaid material matter as follows:

(at p. 40)

Q. Who have you received compensation from over \$1000 since 2002?

A. Midwest Merger Management, Brentwood, Certified Services.

\* \* \* \* \*

Q. Anybody else?

A. Not that I recall. You know, that's just what I said.

\* \* \* \* \*

(at pps.259-261)

Q. Mr. McCartha, I'm showing you a copy of SEC's composite Exhibit number 90.<sup>1</sup>

Can you flip thorough these documents—

A. Sure.

Q. And identify those documents for me?

A. These are related to a PEO that Mr.- that was the Service Pro PEO. Nothing to do with any type of letters of credit or anything of that nature.

\* \* \* \* \*

---

<sup>1</sup> Exhibit 90 consisted of 9 checks drawn on a bank account of Strategic Bancorp, dated between February 2003 and September 2003, made payable to the defendant, totaling approximately \$ 54,267.25.

Q. Again, why did you receive compensation from Strategic Bancorp?

A. We, refer- I referred several different PEO's to him - or not just PEO's, but anybody that would ask me, I would tell them about his operation. He had this Service Pro PEO, which was his, and it was a - was not his, it was the people that he had relations to. And this was related to those PEO's that came to him.

\* \* \* \* \*

Q. Earlier when we spoke during your testimony today we asked you who you'd received compensation from, and you did not mention Strategic Bancorp; is that correct?"

A. Yes, I didn't and I-

Q. Was that an error?

A. That was a substantial error. I did not recall it. I had forgotten about it.

\* \* \* \* \*

Q. How did you and Mr. Leyton arrive at the amount that you should be compensated for your activities?

A. You know, I really don't recall. One time he wanted to buy a 'Vette down in this area, and I was going to buy a "Vette or look at a 'Vette from him, but I never- you know, we never could buy it.

Q. When you say "'Vette", are you referring to an automobile?

A. An automobile, because he was investing in automobiles, or whatever. And that's all that I recall. I just really didn't even recall, you know, the - didn't even recall the checks.

Q. During the period of time when you received these checks, who else were you getting

compensation from?

A. I don't know. I assume Brentwood and/or MMM- Midwest Merger Management.

50. The above testimony of OTHA RAY MCCARTHA, as he then and there well knew and believed, was false in that the defendant knew that the funds he received from Strategic Bancorp were not related to Service Pro or to the purchase of a Corvette but rather were undisclosed payments in exchange for his involvement in procuring letters of credit for Certified Services, Inc. The above testimony was also false in that the defendant knew that he had received payments from other sources since 2002, namely that he had received payments from Presidion Solutions, Inc., in exchange for his having procured letters of credit for Presidion, resulting in a net profit to him of more than \$1 million.

All in violation of Title 18, United States Code, Section 1621.

#### COUNT 16

51. On or about July 12, 2005, in Miami-Dade County, in the Southern District of Florida, the defendant,

**CHARLES J. SPINELLI,**

having duly taken an oath before Walter Mathews, a competent officer of the Securities and Exchange Commission during an investigation duly authorized by the Commission, a case in which Title 15, U.S.C., Section 78u(b) authorizes an oath to be administered, and having sworn that he would testify truthfully, did willfully and knowingly and contrary to said oath state material matter which he did not believe to be true, that is to say:

52. At the time and place set forth above, the Commission was conducting an investigation

into the practices and financial condition of Certified Services, Inc., to determine whether said corporation had violated certain provisions of the federal securities laws. It was material to the aforesaid investigation to determine the relationship that Brentwood Capital Corporation had with Certified and, in this regard, to understand the financial structure of Brentwood Capital.

53. At the time and place set forth above, CHARLES J. SPINELLI appeared as a witness before the Commission, and then and there being under oath, testified falsely before the Commission with respect to the aforesaid material matter as follows:

(at pps. 121-123)

Q. I'm going to mark the next exhibit SEC's Exhibit No. 390.....I'm going to show that to you, Mr. Spinelli—is a web printout of a web address of Brentwood Capital Corporation at bccfinance.com. ....

\* \* \* \* \*

Q. Let's look at the first item on the first page. It says, "Bloom & Company, LOC (sic)?"

A. Uh-huh.

Q. And that is described as "an accounting firm which acts as auditor for Brentwood," and then it says "portfolio" part of it is cut off. Is that an accurate statement?

A. No.

Q. Why not?

A. Because they never acted as an auditor for Brentwood.

Q. Did they perform any auditing services for Brentwood?

Q. No. Contemplated at one point hiring them to do that.

Q. Did Brentwood Capital Corporation provide any money to Bloom & Company for doing accounting work?

A. Well, let me specify, if I may. I interpreted the question to be, did Bloom and Company do any accounting or auditing work for Brentwood Capital. And the answer to that is no, never has. Bloom and Company did do some work for Brentwood Capital—for Midwest, one word, MHG, Momentum Holdings Group, which was a partially-invested or a subsidiary of Brentwood—it wasn't a Subsidiary, it was a public shell that Brentwood Capital invested in and purchased. Bloom & Company did work for them. Sorry if that was a long-winded explanation.

Q. No, thanks. I just want to clarify things. Was Bloom & Company ever retained to do any accounting work for Brentwood Capital?

A. No.

54. The above testimony of CHARLES J. SPINELLI, as he then and there well knew and believed, was false in that the defendant was aware that Bloom and Company had been contracted to do auditing work for Brentwood, and that Bloom and Company had initiated the audit, received payment for the audit and was fired from the audit, after the auditor asked questions regarding a \$5 million asset that Brentwood was claiming it had received as payment of a commission from Strategic Bancorp.

All in violation of Title 18, United States Code, Section 1621.

A TRUE BILL

*Claudette A Crowder*  
 FOREPERSON

*Rogert H. Steffen*  
 R. ALEXANDER ACOSTA  
 UNITED STATES ATTORNEY

*Rogert H. Steffen*  
 ROGER H. STEFFEN  
 ASSISTANT UNITED STATES ATTORNEY

United States District Court,  
D. Connecticut.  
UNITED STATES FIDELITY AND GUARANTY COMPANY, Discover Reinsurance  
Company, and Discovery Managers, Ltd., Plaintiffs,  
v.  
S.B. PHILLIPS COMPANY, INC., Defendant.  
No. 3:01CV2018(DJS).  
March 8, 2005.

**Background:** Insurer and its underwriter and reinsurer subsidiaries brought action against insured seeking declaratory relief and damages for breach of contract, and insured and its chief executive officer filed tort counterclaims. Parties filed motions for summary judgment. **Holdings:** The District Court, Squatrito, J., held that: (1) reinsurance agreement between insurer and its subsidiary reinsurer did not create privity of contract between reinsurer and insured; (2) reinsurer and underwriter would be permitted to voluntarily dismiss their claims; (3) amendment to indemnity agreement accelerated the original time-table for review and possible reduction of security in original agreement; (4) fact issue as to whether insurer correctly calculated amount of premium owed by insured precluded summary judgment on issue of damages; (5) indemnity agreement and that agreement's merger clause did not bar insured's claims against insurer for promissory estoppel, negligent or fraudulent misrepresentation, or fraud in the inducement; (6) fact issues precluded summary judgment on insured's tort claims; and (7) reinsurer's draw down of letter of credit posted by insured as security did not support conversion claim. Motions granted in part and denied in part.

#### **MEMORANDUM OF DECISION**

SQUATRITO, District Judge. Plaintiff United States Fidelity and Guaranty Company has moved for summary judgment on all counts of the complaint. Plaintiffs United States Fidelity and Guaranty Company, Discover Reinsurance Company and Discovery Managers, Ltd., in their capacities as counterclaim defendants, have moved for summary judgement on some of the counterclaims brought by both the defendant, S.B. Phillips Company, and defendant's CEO Sam Phillips. Discover Reinsurance Company and Discovery Managers, Ltd. have also moved to voluntarily dismiss their claims.<sup>FN1</sup> The motion for summary judgment [**doc. # 197**] is **GRANTED in part**, and the motion to dismiss [**doc. # 201**] is **GRANTED**, for the following reasons.

FN1. Discover Reinsurance and Discovery Managers have essentially asked the court to dismiss them as plaintiffs for lack of standing.

#### **Facts**

This action arises out of a contract for the provision of insurance. Plaintiff United States Fidelity and Guaranty Company ("USF & G") is an insurance company organized under Maryland law. Defendant S.B. Phillips Company, Inc. ("S.B. Phillips") is a family-owned South Carolina corporation engaged primarily in the provision of temporary staffing services throughout the southeast region of the United States. As a result of its core business operations, S.B. Phillips is required to have large amounts of insurance coverage, especially workers' compensation insurance. During the 1990s, S.B. Phillips

decided to explore options for reducing the rising costs of obtaining insurance. Marsh USA, Inc, an insurance brokerage firm incorporated in Delaware and operating in South Carolina, was retained by S.B. Phillips in 1996 for this purpose. S.B. Phillips asked Marsh, in early 1999, to find insurance options that would lower the cost of insurance through monetary credit for S.B. Phillips's successful efforts to reduce the risk of its employees and, accordingly, the risk of loss under its insurance policies. Marsh contacted Discovery Managers, Ltd. ("Discovery") a Connecticut based subsidiary of Discover Re Managers, Inc. ("Discover Re"). Discover Re is a wholly owned subsidiary of USF & G, consisting of three separate companies engaged in the underwriting and reinsurance or a certain brand of high-risk insurance policies called Alternative Risk Transfer vehicles ("ARTs"). Discovery handles the underwriting and issuance of insurance policies. Discover Reinsurance Company ("Discover"), an Indiana corporation that reinsures the policies underwritten by Discovery, is also wholly owned by Discover Re and, in its turn, USF & G. All of the Discover Re companies operate out of facilities located in Farmington, Connecticut. Discovery is licensed by USF & G to underwrite ARTs, including the species of policy known as a self-funded retention ("SFR"), so-called because these policies require the insured to pay a very large \*195 deductible on any claims. Marsh and Discovery approached S.B. Phillips and discussed the benefits of the SFR insurance policies with the defendant's CEO, Sam Phillips ("Sam"), and his son, **Blanton Phillips** ("Blanton"), the COO. Discovery's representative, Kristina Landini ("Landini"), met with Sam and Blanton on March 11, 1999 at the S.B. Phillips offices in Greenville, South Carolina. Also present at the meeting was Brian Morgan ("Morgan"), a representative of Marsh. Landini explained the parameters of the SFR program and also touted the virtues of a captive insurance company, an off-shore company owned by the insured that would provide numerous tax benefits of an unspecified nature. Critically for this case, Landini informed Sam and Blanton that security might be required to indemnify USF & G against any losses incurred up to the amount of the self-funded retention. According to Blanton, Landini said the security would "probably" be a one-year issue and any collateral offered by S.B. Phillips would not be held indefinitely. Sam and Blanton both testified that they understood the need for security to be a limited requirement subject to elimination after one year, although neither man can state precisely who gave them this impression. Marsh and its agents are credited as the source of the Phillips' beliefs regarding the collateral. A second meeting was held in Greenville in April, although the record is not clear regarding who attended the second meeting. Other than the March 11 meeting, it appears that all communication between S.B. Phillips and Discovery, throughout the course of the events underlying this litigation, took place indirectly through Marsh, which works with S.B. Phillips's risk manager, Kara DeBorde ("DeBorde"). Generally, either Sam or Blanton would tell DeBorde their concerns regarding the insurance situation and DeBorde would transmit those concerns to agents of Marsh who then worked with Discovery and Discover to resolve disputes. The impressions Sam and Blanton developed about the security and collateral arose as a result of this communication process. The plan developed by Marsh and Discovery worked in the following manner. S.B. Phillips, under the insurance policy issued in 1999, received insurance subject to a \$250,000 deductible (the self-funded retention) per claim. No premiums were required for this policy, but S.B. Phillips was required to indemnify USF & G for all losses that might occur within the SFR. Discover reinsured USF & G for all losses and, pursuant to their reinsurance agreement, was entitled to all benefits, and fully assumed all risks, under the insurance contract and Indemnity Agreement. A similar arrangement existed under the renewed insurance policies issued in 2000. S.B. Phillips, during April 1999, decided to purchase an SFR product from USF & G. Marsh and Discovery worked out the details that have already been described.

Discovery issued policies, in USF & G's name, for worker's compensation insurance, general liability insurance and errors and omissions insurance effective for a period of one year from April 30, 1999. The worker's compensation policies had a \$250,000 deductible and the general liability policies had a \$200,000 deductible.<sup>FN2</sup> Discovery, upon completion of an internal audit of S.B. Phillips's finances decided that the company was not a suitable candidate for an SFR product, although this conclusion was, at least based on the record, not made known to S.B. Phillips and it did not stop Discovery from selling the \*196 SFR policies to the defendant. Approximately two weeks after the policies went into effect, Discovery sent Marsh a copy of the Indemnity Agreement that included the description of the collateral required to secure the SFR.

FN2. No security was required under the general liability policies. The security and collateral served only to guarantee the SFR under the worker's compensation policies.

Apparently as a result of the review of S.B. Phillips's finances, Discovery determined that a much larger amount of security would be required than Sam or Blanton had understood to be necessary. The Indemnity Agreement called for a \$1.9 million security in the form of an "evergreen" letter of credit, so-called because it can be drawn on by the beneficiary at any time for any reason. Sam and Blanton testified that they were surprised and shocked by the amount of the security, but they felt constrained by their legal obligation to carry insurance, since any rejection of the Indemnity Agreement would end their insurance coverage and, simultaneously, their legal ability to do business as a temporary staffing agency. Further, Sam and Blanton believed the security would be reduced after one year, although the express terms of the Indemnity Agreement did not provide for such a reduction. Again, Sam and Blanton claim to be relying on general statements of reassurance made by Discovery, through Marsh. S.B. Phillips signed the Indemnity Agreement and arranged for the Branch Banking & Trust Company ("BB & T") to provide the letter of credit, which was issued on May 26, 1999, with Discover Reinsurance as the beneficiary. A similar pattern of events occurred in April 2000, when the initial policies were subject to renewal. S.B. Phillips was informed, close to the expiration of its insurance, that a much larger amount of security would be required for the second year of coverage, in spite of S.B. Phillips's work to hold claims to a minimum. Plaintiffs required an additional \$2,509,175 as security for the re-issuance of the insurance policies. S.B. Phillips agreed to provide the increased security, and USF & G agreed to amend the Indemnity Agreement, although the parties do not present these changes as a reciprocal arrangement. The exact result of Amendment No. 1, which took effect April 30, 2000, is the subject of this lawsuit. There is no dispute that BB & T renewed the initial letter of credit and also issued a second letter of credit on April 27, 2000, with Discover as the beneficiary of both. S.B. Phillips, its assets encumbered as collateral for the letters of credit, began to search for a new insurance provider in early 2001, and the active relationship between USF & G and S.B. Phillips ended in May 2001. The Indemnity Agreement was amended a second time, on May 1, 2001, to reflect an extension of the coverage period under the second insurance policy from May 1, 2001 to May 15, 2001. No further security was requested at the enactment of Amendment No. 2, although S.B. Phillips was required to maintain security under the now expired insurance contracts covering the period from April 30, 1999 to May 15, 2001. Discovery reviewed the security required under the first insurance policies at this time and determined that the \$1.9 million sum could be reduced to \$1.2 million. BB & T replaced the original letter of credit with a new letter for \$1.2 million on May 15, 2001, again with Discover as the beneficiary. The continued maintenance of the letters of

credit became the sole basis for the interactions of USF & G and S.B. Phillips. Discover reviewed the outstanding security as required by the Indemnity Agreement in May 2002 and informed S.B. Phillips that the total security could be reduced to \$1,951,786. BB & T issued a new letter of credit, replacing both the \$1.2 million letter and the approximately\*197 \$2.5 million letter, on May 24, 2002. The new letter of credit identified USF & G as the beneficiary, replacing Discover Reinsurance. The letter of credit was amended on July 8, 2002 to reflect yet another downward revision of the security, to \$1,164,286 million. Again, USF & G was the named beneficiary. On November 26, 2002, for reasons that are not explained in the record, Discover attempted to draw down the July 2002 letter of credit in the amount of \$1,005,525. Throughout the period from May 2001 to May 2003, S.B. Phillips was in almost constant conflict with USF & G and Discover regarding the amount of security required. USF & G repeatedly threatened to draw down the letter of credit if S.B. Phillips refused to authorize a new letter each year when the security was renewed. The record does not say if Discover's actions were related to one of these disputes, although such an inference is not unreasonable when the facts are taken in a light most favorable to the defendant. The money was paid, after some dispute regarding the proper bank account into which the money should be deposited. According to testimony in the record, the money was not properly segregated but was instead commingled, temporarily, with money held generally by Discover. The money was eventually returned, in full, to Sam Phillips, although the reasons for this action are not explained in the record. The money was returned to Sam rather than to S.B. Phillips because, at some point after 1999, Sam Phillips began to provide the collateral for the letters of credit with his personal assets. S.B. Phillips changed bankers in 2002 and the new bank, First Citizen's Bank, issued a new letter of credit on December 19, 2002.<sup>FN3</sup> This letter, in the amount of \$1,005,525, named USF & G as the beneficiary. The maturity of the December 19 letter of credit was extended, in April 2003, to May 31, 2003 and again extended, on May 30, to November 30, 2003. The amount secured by the letter of credit was reduced on May 30, 2003 to \$624,598.

FN3. It is possible to infer that Discover Reinsurance drew on the letter of credit because BB & T refused to issue a new letter of credit as a result of its impending loss of business with S.B. Phillips. This conclusion may be inferred from, but is not stated in, the record.

### **Standard of Review**

Summary judgment may be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). Summary judgment is appropriate if, after discovery, the nonmoving party "has failed to make a sufficient showing on an essential element of [its] case with respect to which [it] has the burden of proof." Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). "The burden is on the moving party 'to demonstrate the absence of any material factual issue genuinely in dispute.'" American Int'l Group, Inc. v. London Am. Int'l Corp., 664 F.2d 348, 351 (2d Cir.1981) (quoting Heyman v. Commerce & Indus. Ins. Co., 524 F.2d 1317, 1319-20 (2d Cir.1975)). A dispute concerning a material fact is genuine "if evidence is such that a reasonable jury could return a verdict for the nonmoving party." Aldrich v. Randolph Cent. Sch. Dist., 963 F.2d 520, 523 (2d Cir.1992) (quoting Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986)). The court must

view all inferences and ambiguities in \*198 a light most favorable to the nonmoving party. See *Bryant v. Maffucci*, 923 F.2d 979, 982 (2d Cir.1991). “Only when reasonable minds could not differ as to the import of the evidence is summary judgment proper.” *Id.*

### **DISCUSSION**

Plaintiff USF & G seeks summary judgment on Counts One and Two of the Complaint. Plaintiffs Discover and Discovery have moved the court to dismiss Counts One and Two of the Complaint and Counts One and Two of the Counterclaim on the grounds that Discover and Discovery are not in privity of contract with S.B. Phillips and thus can neither sue nor be sued on the contract. All three plaintiffs, in their capacities as counterclaim defendants, move for summary judgment on Counts Three through Nine and Eleven through Eighteen of the Counterclaim.<sup>FN4</sup>

FN4. The plaintiffs have made all arguments for summary judgment jointly unless it is specifically noted otherwise. For the sake of simplicity, plaintiffs will be referred to collectively as USF & G when discussing their joint motion.

#### **I. Discover's and Discovery's Motion to Dismiss**

Discover Reinsurance and Discovery Management, Ltd., have submitted a motion to dismiss their claims for a declaratory judgment and for damages under Counts One and Two of the Complaint. Plaintiffs' basis for their motion is unusual. Discover and Discovery now claim that, because they lack privity of contract with S.B. Phillips, they do not have standing to sue on the contract. See, *Tomlinson v. Board of Education of the City of Bristol*, 226 Conn. 704, 718, 629 A.2d 333 (1993). Thus, plaintiffs argue, the court must accept their motion to dismiss pursuant to F.R.C.P. 41(a)(2). If the plaintiffs' motion is granted, they will remain as parties only in their capacities as counterclaim defendants to the claims brought by S.B. Phillips and Sam Phillips. The motion is unusual because it is typically the defendant that moves to dismiss an action when, as Discover and Discovery contend, the cause of action is brought by a party not in privity of contract with the defendant. Here, the defendant, S.B. Phillips, is in the position of arguing that Discover and Discovery are entitled to sue and be sued on the contract. If plaintiffs' motion is denied, the effect will be to award Discover and Discovery legal rights that they presently disown. [1] [2] It is an undisputed principle of Connecticut law that a contract for reinsurance does not give rise to a right of action by the insured against the reinsurer, unless there is a specific contractual provision that recognizes such a right. *Brogan v. Macklin*, 126 Conn. 92, 94, 9 A.2d 499 (1939). The basis for this rule is the lack of privity between the reinsurer and the insured. *Travelers Indemnity Co. v. Household International, Inc.*, 775 F.Supp. 518, 526 n. 10 (D.Conn.1991)(holding that a parent company of a subsidiary insurer was not the real party of interest in place of the subsidiary that was the actual issuer of the insurance policy, in spite of a reinsurance agreement giving rights and duties to the parent company). Similarly, in Connecticut “an agent is not liable where, acting within the scope of his authority, he contracts with a third party for a known principal.” *Rich-Taubman Associates v. Commissioner of Revenue Services*, 236 Conn. 613, 619, 674 A.2d 805 (1996). [3] [4] Discover, pursuant to the reinsurance agreement, holds all the risk and all the benefits incurred by USF & G \*199 under the insurance policies and Indemnity Agreement, but there is nothing in either the policies or the Agreement that creates privity of contract between S.B. Phillips and Discover. The mere existence of the reinsurance agreement is insufficient to create privity of contract without something more, and nothing more can

here be found. Discovery, acting to sell and underwrite insurance policies on behalf of USF & G, is an agent of USF & G and USF & G was clearly disclosed as the principal, bringing Discovery within the scope of the general rule of law exempting agents from liability. Connecticut law plainly instructs that Discover and Discovery cannot sue on the insurance policies unless there is explicit language in the policies, or in other contracts between the parties, that authorizes such a cause of action. [5] S.B. Phillips argues that the court has equitable powers to keep Discover and Discovery in the case as plaintiffs, but there is no basis in the record for a holding that the plaintiffs are estopped from dismissing their claims. Implicitly, S.B. Phillips is contending that Discover and Discovery are parties in interest under F.R.C.P. 17(a)<sup>FN5</sup> and therefore they must be retained as plaintiffs. The rule that a claim must be prosecuted by the real party in interest is intended to protect "individuals from harassment and multiple suits by persons who would not be bound by the principles of claim preclusion if they were not prevented from bringing the subsequent actions." 6A Charles A. Wright, Arthur R. Miller & Mary Kay Kane, Federal Practice and Procedure § 1541, at 322 (2d ed.1990). There is no danger to the defendant in this action that Discover and Discovery may bring further suits on the same transactions if USF & G loses on its claims. Discovery, as the agent of USF & G, has no independent right to sue on the contract. Discover also has no right to enforce the contract, despite the assignment clause contained in the reinsurance agreement, because the reinsurer is not in privity with the insured. Brogan, 126 Conn. at 94, 9 A.2d 499. The resolution of USF & G's claims against S.B. Phillips will resolve, finally, any interest that Discover or Discovery have in this case. The purpose of Rule 17(a) is satisfied and there is no basis for the court to hold either Discover or Discovery in the case as plaintiffs against their wishes. The motion to voluntarily dismiss Counts One and Two of Complaint is granted.

FN5. "Every action shall be prosecuted in the name of the real party in interest." F.R.C.P. 17(a).

[6] [7] Finally, the issue remains as to the viability of S.B. Phillips's contract-based counterclaims against Discover and Discovery. The plaintiffs are not parties to the insurance policies or the Indemnity Agreement, nor do they have any rights to enforce those agreements. Absent privity of contract there is no standing to bring an action on the contract and the claims must be dismissed. Similarly, S.B. Phillips has no standing to sue non-parties to the agreement for breach of the agreement. The court lacks subject matter jurisdiction when the plaintiff has no standing to pursue the action. In re Catholic Conference, 885 F.2d 1020, 1023 (2d Cir.1989). A federal court must dismiss a claim, and may do so sua sponte, whenever it is established that the court lacks subject matter jurisdiction. Westmoreland Capital Corp. v. Findlay, 100 F.3d 263, 266 (2d Cir.1996). The lack of privity is therefore fatal to Counts One and Two of the counterclaim to the extent that those counts state causes of action based on contract against \*200 Discover and Discovery. The claims against Discover and Discovery are therefore dismissed for lack of subject matter jurisdiction pursuant to F.R.C.P. 12(h) and F.R.C.P. 41(b).<sup>FN6</sup>

FN6. The court notes that it is a precondition of dismissal pursuant to Rule 41(a)(2) that the voluntary dismissal not lead to the dismissal of counterclaims filed prior to the motion to voluntarily dismiss. F.R.C.P. 41(a)(2). The requirement of the rule does not, however, permit the court to retain a claim over which it lacks subject matter jurisdiction.

Discover and Discovery are terminated as plaintiffs in this action.

## II. Plaintiff's Motion for Summary Judgment on the Complaint

USF & G, as the party named on the insurance policy and the signatory to the Indemnity Agreement, has privity of contract with S.B. Phillips and can both sue and be sued on the contract at issue in this action. USF & G remains in the case as a plaintiff and its claims are not affected by the dismissal of Discover and Discovery as plaintiffs.

### A. Count One-Declaratory Judgment

USF & G moves for summary judgment on its claims for a declaratory judgment and damages arising out of an alleged breach of contract. USF & G and S.B. Phillips entered into an Indemnity Agreement dated April 30, 1999 ("the Agreement"). The Indemnity Agreement was subsequently amended twice. Amendment No. 1 ("the Amendment") took effect on April 30, 2000 and Amendment No. 2 became effective on May 1, 2001. This action is predicated on a dispute between the parties about the meaning of certain provisions of Amendment No. 1 to the Indemnity Agreement. Count One of USF & G's complaint seeks a declaratory judgment that it was not required, by the terms of the Indemnity Agreement, to review and possibly reduce the amount of the security provided by S.B. Phillips until April 30, 2002. Defendant contends that Amendment No. 1 to the Indemnity Agreement accelerated the original time-table for review and possible reduction of the security so that USF & G was obligated to reduce the amount of security on April 30, 2001. The parties agree that Connecticut law governs the interpretation of the Indemnity Agreement and Amendment No. 1. [8] [9] [10] Under Connecticut law, the intention of the parties is controlling and must be gathered from the language of the [contract] in light of the circumstances surrounding its execution. *Peter-Michael, Inc. v. Sea Shell Associates*, 244 Conn. 269, 275, 709 A.2d 558 (1998). Intention is determined by the language of the contract, the circumstances of formation, and the motives and purposes of the parties. *Sartor v. Town of Manchester*, 312 F.Supp.2d 238, 243 (D.Conn.2004). The contractual language must be given its ordinary meaning unless some special meaning is clearly intended. *Id.* Finally, the contract must be construed as a whole so that every provision is given effect, if reasonably possible. *Id.* [11] [12] [13] [14] Generally, contractual intent is a question of fact, but it can be a question of law for the court when the contractual language is clear and unambiguous. *Sartor*, 312 F.Supp.2d at 243. "If the agreement is subject to more than one reasonable interpretation and extrinsic evidence of the actual intent of the parties exists, then the contract's meaning becomes an issue for the factfinder." *Brunoli v. Brunoli & Sons*, 993 F.Supp. 66, 73 (D.Conn.1997). When the terms of a contract containing a valid merger clause are unambiguous, the introduction of extrinsic evidence \*201 of intent will be barred. *Tallmadge Brothers Inc. v. Iroquois Gas Transmission System, L.P.*, 252 Conn. 479, 503-504, 746 A.2d 1277 (2000). A contract's language is presumed to be unambiguous when the contract is a commercial agreement between sophisticated parties. *Id.* at 496, 746 A.2d 1277. The critical underlying issue is whether the terms of the Indemnity Agreement and Amendment No. 1 are clear and unambiguous such that the intent of the parties can be determined as a matter of law. [15] The Indemnity Agreement establishes the rights and duties of the insurer and the insured under the SFR program. The document covers such issues as the amount of required security, the terms and conditions for determining the security and reducing it and the calculation of premiums and other fees. The First Count of USF & G's complaint deals strictly with those provisions of the Agreement governing the timing of USF & G's review of the security provided by S.B. Phillips to guarantee the SFR. The clause entitled "Decreases," found at Paragraph C(2) of Section VI of the Indemnity Agreement, guarantees to S.B. Phillips that the amount of the security will be reviewed on the second

anniversary of the termination date of the underlying insurance policy, and reduced if certain conditions are satisfied. There is no dispute that security under the first policy, covering the period from April 30, 1999 to April 30, 2000, was subject to review as of April 30, 2002 under the unmodified Indemnity Agreement. The terms under governing reduction of the security were altered by Amendment No. 1. The Amendment was executed in conjunction with the second insurance policy, on April 30, 2000. According to Amendment No. 1, decreases may occur as of the first anniversary of the termination of the policy.<sup>FN7</sup> There is no language in Amendment No. 1 that restricts its effect on the Indemnity Agreement to only those insurance policies issued on or after April 30, 2000.

FN7. Amendment No. 1 reads, in relevant part, “[A]s of the first anniversary of the termination date of the Policy and on each anniversary thereafter, Company will allow a reduction in the then current amount of security if such amount is greater than the Retention Obligations valued at such anniversary dates.”

The Indemnity Agreement contains a valid merger clause. The clause reads, in relevant part, “[t]his Agreement supersedes all previous Indemnity Agreements between Company and Insured as to the subject matter covered by this Agreement, and any prior statements, agreements or representations between the parties are terminated and no longer of any force and effect.” The terms of the merger clause were not altered or affected by either Amendment No. 1 or Amendment No. 2 and the clause remains applicable to the entire contract, as amended. USF & G argues that the terms of the contract are unambiguous. According to the plaintiff, Amendment No. 1 actually creates two distinct Indemnity Agreements with different prescriptions for the reduction of the security provided by S.B. Phillips. The original, unmodified Indemnity Agreement applies to the first policy, in effect from April 30, 1999 to April 30, 2000, while the amended Indemnity Agreement creates a new deadline for review of the security produced in conjunction with the second policy, in effect from April 30 2000 to April 30, 2001. USF & G attempts to provide textual evidence in support of this claim. First, plaintiff argues that the execution date of the Amendment, April 30, 2000, is **\*202** a clear sign that it was meant to apply only to the insurance policy executed on that date, although no language in the amendment fits this interpretation. Second, USF & G claims that the “pooling provision” in the amendment is a clue that the parties intended Amendment No. 1 to merge the time of review for the security required under both the first and second insurance policies by accelerating the review of the security for the second policy. Again, there is nothing in the “pooling provision” that limits application of the amendment. Finally, plaintiff argues that because the amendment alters the schedule of policies to include the second policy but does not mention the first policy, Amendment No. 1 must apply to only the second policy. There is no language in the paragraph amending Schedule A that limits application of the amended Indemnity Agreement to only the second policy. S.B. Phillips contends that the contractual language is clearly ambiguous because it can have an alternate interpretation. Defendant alternately claims, in a footnote, that it is entitled to summary judgment on this issue because, in fact, the language of Amendment No. 1 is not ambiguous and it requires a review and possible reduction of collateral on April 30, 2001. [16] The language of the Indemnity Agreement as amended is clear and unambiguous. Ultimately, none of the parties claim that the provision altering the date on which the collateral is reviewed from two years after termination to one year is actually subject to multiple interpretations. The change is obvious and not disputed. The meaning of the language is not subject to debate; rather the scope of the amended contract is disputed. Ambiguity must “emanate from the

language of the contract rather than on party's subjective perception of the terms." *Tallmadge*, 252 Conn. at 498, 746 A.2d 1277. The parties have a subjective dispute, rather than a textual one and therefore the question of contractual meaning is a matter of law. The fact that, here, contractual meaning is a question of law does not necessarily lead to the conclusion that USF & G is correct as to the meaning of the contract. The execution date of the amendment offers no insight into the meaning of the contract. The fact that the Indemnity Agreement was amended when the second policy took effect is proof only of dissatisfaction with the Agreement as originally conceived. An amendment alters the original agreement, it does not create an alternate agreement in competition with the original. A failure to mention the first policy in the amendment is also evidence of nothing. The section amending Schedule A is titled "Schedule A is amended to add the following additional Policy." This meaning is clear and unambiguous. Schedule A existed in one form until April 30, 2000 and then it was amended to include new and previously absent information. Obviously there is no need to include the information already contained in Schedule A because the schedule is being supplemented, not replaced. The second policy is now covered under the Indemnity Agreement in addition to any policies already covered. The absence of any mention of the first policy in the amendment is logical because the first policy is addressed in the original Indemnity Agreement and does not need to be reviewed in the Amendment. The pooling provision is equally unconvincing as proof of an intent to split the Indemnity Agreement. The reference to all of the security as a single entity, when read in conjunction with the other portions of Amendment No. 1, is best understood as an application of the amended Indemnity Agreement to both policies, rather than as the creation of two separate Indemnity \*203 Agreements. Indeed, if the Amendment were intended to create a competing agreement it would make much more sense to refer to the second policy with specificity in each amendment or alteration. The language of Amendment No. 1 conspicuously fails to include any limits or specific applications. The Amendment can be clearly read as an alteration of the original Agreement as that Agreement applies to both the first and second insurance policies, not as an effort to split the original Agreement in two. USF & G does not claim that the merger clause should not apply or that extrinsic evidence exists to support its desired interpretation. Plaintiff attempts to foist a meaning on the text of Amendment No. 1 that simply does not fit. The language of the Amendment is clear and it alters the terms of the original Indemnity Agreement. There is only one Agreement and it applies with equal force to both policies. A court may sua sponte grant a motion for summary judgment in favor of the non-moving party, just as if a cross-motion for summary judgment had been filed, so long as the record is sufficiently developed that the moving party suffers no prejudice as a result of the decision. *Coach Leatherware Co., Inc. v. AnnTaylor, Inc.*, 933 F.2d 162, 167 (2d Cir.1991). USF & G has submitted a reply brief that does not address S.B. Phillips' claim for summary judgment. It is impossible to say that plaintiff would be prejudiced where it has failed to respond to a claim of which it has notice.<sup>FN8</sup> The terms of Amendment No. 1 alter the "Decreases" clause of the Indemnity Agreement to require a review and reduction of the collateral one year from the termination of the relevant policy. Thus, USF & G was obligated to review the security posted by S.B. Phillips in conjunction with the first insurance policy on April 30, 2001. The plaintiff's motion for summary judgment is denied on Count One and summary judgment is granted to S.B. Phillips.

FN8. USF & G did claim that S.B. Phillips was barred from arguing that it was entitled to a favorable ruling because of a contradictory allegation included in one of its counterclaims. The court finds no merit in this argument. It is absolutely true, and

undisputed by the parties, that S.B. Phillips was entitled to a review and possible reduction of all security on May 15, 2002. The fact that some review would be required on the undisputed date does nothing to preclude a finding that review of the security was actually required at an earlier date.

### **B. Count Two-Damages**

[17] USF & G has also moved for summary judgment on Count Two of its complaint. Plaintiff seeks \$114,933 in unpaid premiums, together with prejudgment interest, allegedly owed under the 1999 insurance policy. The policy guarantees that the annual premium S.B. Phillips must pay will be determined by USF & G's manuals of "rules, rates, rating plans and classifications." The manuals are subject to change at any time. Premium payments must be paid at the time specified by USF & G. The final premium payment is determined after termination of the policy by reference to the actual expenditures that are considered as part of the premium basis, rather than the estimates used in the policy. USF & G is both authorized and required to conduct an audit of S.B. Phillips's records for the purpose of assembling the information needed to issue the final premium amount. Plaintiff retains the right to conduct the audit at any time up to three years after the policy period ends. USF & G claims that it conducted an audit in late 2000 and determined that the outstanding premium on the first policy was \$139,351. According to DeBorde, the \*204 director of risk management for S.B. Phillips, the audit statement reflects Discovery's assessment of the premium S.B. Phillips owed on the insurance policy. Marsh also calculated a premium, one that DeBorde said was more accurate than Discovery's proposal. DeBorde testified that S.B. Phillips had not been billed for the premium and this was the reason USF & G had not been paid. Subsequently, USF & G adopted Marsh's premium calculation, in the amount of \$114,933, and submitted an invoice for this sum. S.B. Phillips refused to pay the invoice and that refusal spawned the present action. Taking all facts and inferences in the light most favorable to S.B. Phillips, a reasonable juror could conclude either that the audit and premium calculation violated the contract or that the amount of the premium is wrong. There is no testimony from the auditor and nothing in the record that explains when the audit was conducted, what records were consulted or the methods used to derive the amount of the premium. The letters attached to the alleged audit report also suggest that USF & G did not actually review S.B. Phillips's business records as required by the contract. The letters, from Marsh to Discovery, disclose Marsh's disagreement with the amount of the premium and include offers from Marsh to produce S.B. Phillips's company records for review, a process, arguably, that was contractually obligated to occur prior to determination of the outstanding premium. The record is too much in doubt regarding the sum owed by S.B. Phillips to grant summary judgment. There are clear issues of fact related to the calculation of the premium and the amount of the premium. Drawing all inferences in a light most favorable to the defendant, a reasonable fact-finder could conclude that USF & G did not meet its contractual obligation when determining the amount of the premium and thus has not yet identified the correct amount owed by S.B. Phillips. Further, although DeBorde testified that Marsh had accurately calculated the premium, it is not clear that she was qualified to make this assessment, that her statement is accurate or that S.B. Phillips is obligated to pay the premium even if accurately calculated. The record presented to the court does not satisfactorily resolve all material issues of fact in dispute. Summary judgment on Count Two of the Complaint is denied.

### **III. Counterclaim Defendants' Motion for Summary Judgment on the Counterclaims**

USF & G, Discovery and Discover, in their capacities as counterclaim defendants, have moved for summary judgment on Counts Three through Nine and Eleven through Eighteen of the Second Amended Counterclaim. They argue that South Carolina law governs the tort claims brought by S.B. Phillips and that under South Carolina law summary judgment is warranted. Counterclaim plaintiffs <sup>FN9</sup> oppose summary judgment. S.B. Phillips contends that Connecticut law governs the tort claims and that genuine issues of material fact exist which preclude summary judgment.

FN9. Sam Phillips is named as a counterclaim plaintiff, although he is not named as a defendant in the original action. All arguments made by both Sam Phillips and S.B. Phillips will be treated as brought by S.B. Phillips unless otherwise noted.

#### **1. South Carolina Law Controls...**

The contacts present in the record, both in quantity and quality, lead convincingly to the application of South Carolina law to the non-contract claims. The insurance contracts and the Indemnity Agreement were created in South Carolina and arranged by a South Carolina-based broker for a South Carolina business. The injuries allegedly suffered by the counter-claim plaintiffs occurred in South Carolina. The insurance policies covered activities that occurred in South Carolina and other southeastern states. Finally, any state law interest that might be implicated in this action-regarding the fiduciary duty or marketing obligations of an insurance broker, reinsurer or insurance underwriter-belongs to South Carolina, where the policy was sold and the insured is located. S.B. Phillips asserts that Connecticut has more significant contacts with this case than South Carolina does, but that assertion is not substantiated. Discovery, the underwriter of the insurance policies, and \*207 Discover, the reinsurer of USF & G, are Connecticut-based companies, and undoubtedly they have a legitimate interest in the outcome of this case, but that interest alone is insufficient to make Connecticut law applicable to the non-contract claims. Even if the court assumes that Discovery and Discover, not USF & G, are the real parties in interest, as S.B. Phillips implicitly argues, it remains a fact that Discovery was doing business in South Carolina when it sold insurance to the defendants, and South Carolina is the locus of the relationship between the parties.

#### **2. CUIPA and CUTPA Claims are Dismissed**

S.B. Phillips brings four counterclaims for damages under the Connecticut Unfair Trade Practices Act ("CUTPA") and the Connecticut Unfair Insurance Practices Act ("CUIPA"). These claims are based on Connecticut statutory law and may not be brought pursuant to the law of any other state. The application of South Carolina law to all non-contract claims in this action is fatal to Counterclaim Counts Eight and Fifteen (CUIPA) and Counts Nine and Sixteen (CUTPA). Summary judgment is granted to the counterclaim defendants on all four counts.

#### **3. Claims for Estoppel, Misrepresentation and Fraud**

Counts Four through Seven and Eleven through Fourteen of the Counterclaim state claims for promissory estoppel, negligent misrepresentation, fraudulent misrepresentation and fraud in the inducement. USF & G argues that these eight claims should be dismissed because: a) the existence of the Indemnity Agreement and the

Agreement's merger clause forecloses claims for damages based on oral statements that contradict the terms of the Agreement; and b) the record is devoid of actionable statements that support the claims. Neither contention is adequate to win summary judgment. The evidence in the record shows that genuine issues of material fact preclude summary judgment on the eight tort claims challenged by USF & G. Counterclaim plaintiffs identify two categories of false or misleading statements that... support their claims: 1) Landini's statements during the March 1999 meeting at S.B. Phillips's office; and 2) the statements \*209 made by Landini to Marsh and the statements made by Marsh to S.B. Phillips. Although Landini's statements, taken alone, are not necessarily indicative of a promise, the record as a whole could reasonably support a juror's conclusion that Marsh and Discovery made false representations to S.B. Phillips regarding the nature of the insurance program and the amount of collateral the defendant would need to provide. The critical issue of fact concerns Marsh's status as either the agent of S.B. Phillips or the agent of Discovery and USF & G. If Marsh is an agent of S.B. Phillips, then no action can be maintained against the counterclaim defendants based on Marsh's actions. Conversely, if Marsh was acting as the undisclosed agent of Discovery, Discovery and USF & G, then Marsh's statements could expose the counterclaim defendants to liability. There is sufficient doubt as to Marsh's status to permit the issues of fraud and misrepresentation to be heard at trial. Assuming that a jury finds Marsh to be an agent of Discovery, it could be reasonable to award damages to S.B. Phillips on those claims. [28] Under South Carolina law an insurance broker such as Marsh is treated as an agent of the insured. *Hiott v. Guaranty National Insurance Company*, 329 S.C. 522, 530, 496 S.E.2d 417 (S.C.App.1997). However, when there is evidence that would permit an inference that the broker was acting at the instance or request of the insurer, the broker may be treated as an agent of the insurance company under South Carolina Code Ann. § 38-43-10 (1989). Under § 38-43-10 as it existed between 1999 and 2003, a broker who "takes or transmits other than for himself an application for insurance or a policy of insurance to or from an insurer," § 38-43-10(b), or who "receives or delivers a policy of insurance of an insurer," § 38-43-10(d), or who "receives, collects or transmits any premium of insurance," § 38-43-10(e), is considered an agent of the insurer, even if the broker is formally engaged by the insured. Although there are few decisions holding a broker to be an agent of the insurer, see, *Republic Textile Equip. Co. v. Aetna Ins. Co.*, 293 S.C. 381, 383, 360 S.E.2d 540 (S.C.App.1987)(holding that where the insurance company reissued a policy after consulting solely with the broker, the broker could reasonably be considered the agent of the insurer), the facts of this case could permit a reasonable jury to infer that Marsh was the agent of Discovery and USF & G. The record is filled with emails and correspondence showing that, much like the broker in *Republic Textile*, Discovery negotiated premiums and security solely in consultation with Marsh. Internal emails show that Discovery employees discussed the need for Marsh to "convince" S.B. Phillips of the need to acquiesce to Discovery's proposals. Further, the record shows that Marsh collected premiums, delivered the insurance policies and conducted financial surveys of S.B. Phillips that aided Discovery in its business. The statements of Marsh employees regarding the amount of the security and the length of time a security would be required can also be inferred as representations urged by Discovery for the purpose of securing a client, rather than as a disinterested business appraisal such as an insured might expect from its agent. South Carolina law provides that whether an agency relationship exists and the scope of the alleged relationship are questions of fact for a jury. *Holmes v. McKay*, 334 S.C. 433, 439, 513 S.E.2d 851 (S.C.Ct.App.1999). There are sufficient issues of fact regarding the relationship between Marsh and Discovery to make the agency relationship a question for the jury. \*210 The inference that Marsh was the

agent of Discovery, drawn here most favorably to the non-moving party, is sufficient to permit the presentation of all questions of misrepresentation, fraud and estoppel to a jury. Although it might be unreasonable to conclude that Landini's direct statements at the March 1999 meeting, alone, are enough to sustain the tort claims, the complete record, taken in the light most favorable to S.B. Phillips, does contain sufficient evidence. Landini's statements to S.B. Phillips, coupled with her statements to Marsh and Marsh's statements to S.B. Phillips could reasonably be construed as misleading and it could have been reasonable for S.B. Phillips to rely on those representations when deciding to seek insurance from USF & G and Discovery. Once the policies were issued S.B. Phillips had no choice but to accept the terms of the Indemnity Agreement, even if those terms varied from the prior representations of Landini and Marsh. S.B. Phillips must, obviously, prove its allegations at trial, but when the inferences are drawn fully in its favor, summary judgment must be denied as to the tort claims in Counts Four through Seven and Eleven through Fourteen of the Second Amended Counterclaim.

**4. Claim for Breach of Fiduciary Duty...** enough to deny summary judgment.

**5. Claim for Unjust Enrichment...**

**6. Claim for Conversion**

Sam Phillips alleges conversion of property based on USF & G's assignment of its interest in the contractually mandated letters of credit to Discover. Assignment, according to the defendant, is contractually prohibited and therefore USF & G has converted Sam Phillips's property by permitting Discover to claim a right to receive the property to the exclusion of Sam Phillips. Further, Sam Phillips contends that when Discover drew down slightly more than \$1,000,000 on the letter of credit the effect was to convert his property. South Carolina law provides that conversion is the "unauthorized assumption and exercise of the right of ownership over goods or personal chattels belonging to another, to the alteration of their condition or the exclusion of the owner's rights. The record does not sustain the claim of conversion. Initially, the court notes that there is a clear factual question regarding Discover's rights to draw on the letter of credit when USF & G was the only named beneficiary. It may be that Discover's claimed right to the letter of credit, based on USF & G's assignment, was a violation of the Indemnity Agreement and therefore was improper. Assuming this version of the facts, highly favorable to S.B. Phillips and Sam Phillips, is correct, there is still insufficient support for the conversion claim. There is no factual doubt that USF & G had the legal right to draw down the "evergreen" letter of credit at any time and for any reason. Sam Phillips cannot show that he was entitled to possession of the money in question because the letter of credit, by its very existence, denies him exclusive use of his property. Indeed, Sam Phillips repeatedly testified that his inability to have free use of his cash assets was one of the major reasons he sought to reduce the amount of the required security. Further, even if Sam proved that Discover or USF & G had no right to draw upon the letter of credit, the record is clear that the money was subsequently returned to him, at which time it was once again pledged as collateral to secure yet another letter of credit with USF & G as the beneficiary. It cannot be proved that USF & G excluded Sam Phillips from his right to the property-property that was subsequently returned in full without loss of value. The record, even with all inferences drawn in Sam Phillips's favor, cannot support a reasonable fact-finder's conclusion that a conversion occurred. Summary judgment is granted to the counterclaim defendants on this issue.

**CONCLUSION**

The motion by plaintiffs Discover and Discovery to voluntarily dismiss their claims pursuant to F.R.C.P. 41(a)(2) [doc. # 201] is **GRANTED**. Neither Discover nor Discovery is in privity of contract with the defendant and therefore neither can sue on the contract. Counts One and Two of the Complaint are dismissed to the extent that they are brought by Discover or Discovery. Accordingly, Discover and Discovery are dismissed as plaintiffs. The holding that Discover and Discovery lack privity of contract with S.B. Phillips also eliminates the basis for S.B. Phillips' contract claims against those two companies. The court, pursuant to F.R.C.P. 12(h) and F.R.C.P. 41(b), dismisses Counts One and Two of the Counterclaim to the extent they state causes of action against Discover or Discovery. The motion for summary judgment by USF & G in its capacity as a plaintiff is denied. The terms of Amendment No. 1 and the Indemnity Agreement are unambiguous and the claim for a declaratory judgment is properly subject to resolution as a matter of law. The court holds that the Indemnity Agreement, as modified by Amendment No. 1, required USF & G to review and possibly reduce the amount of security, and by extension the amount of collateral, posted by S.B. Phillips to secure the SFR on each insurance policy as of the first anniversary of the termination of the policy. As a result, USF & G was obligated to review the security maintained by S.B. Phillips under the first insurance policy no later than April 30, 2001, the first anniversary of the termination of that policy. Summary judgment is granted to the defendant, S.B. Phillips, on this claim. Further, there exist sufficient issues of material fact regarding the premium payment allegedly owed by S.B. Phillips to deny summary judgment on Count Two of the Complaint. Finally, the joint motion for summary judgment filed by USF & G, Discover and Discovery in their capacities as counterclaim defendants [doc. # 197] is **GRANTED in part**. The terms of the Indemnity Agreement do not require the application of Connecticut law to the various tort counterclaims brought by S.B. Phillips and Sam Phillips. The law of this court's forum state, Connecticut, leads to the application of South Carolina law to all non-contract claims in this action. USF & G is entitled to summary judgment on Counts Eight, Nine, Fifteen, Sixteen, Seventeen and Eighteen of the Counterclaim. Summary judgment is denied as to all other counterclaims. This case is referred to the Hon. Thomas P. Smith, United States Magistrate Judge, for a settlement conference. The parties are **ORDERED** to submit a joint \*213 trial memorandum on or before April 29, 2005.

United States District Court, W.D. North Carolina,  
Charlotte Division.

BACE INTERNATIONAL, INC., StaffAmerica, Inc., and William L Baumgardner, Jr.,  
Plaintiffs,

v.

BRENTWOOD CAPITAL CORPORATION, Certified Services, Inc, The Cura Group,  
Inc., The Cura Group II, Inc., Levy Boonshoft & Spinelli, P.C ., Midwest Merger  
Management, LLC, Danny L. Pixler, W. Anthony Huff, O. Ray McCartha and Ivan  
Dobrin, Defendants.

No. 3:04CV145-MU.

Aug. 22, 2006.

### **BACKGROUND**

Plaintiff StaffAmerica, Inc. ("StaffAmerica") is a wholly-owned subsidiary of Plaintiff Bace International, Inc. ("BACE"). BACE is owned by a single shareholder, Plaintiff Baumgardner. Plaintiff BACE, through StaffAmerica and other subsidiaries, operated a professional employer organization ("PEO"). Plaintiffs filed this action alleging that the Defendants, working together, perpetrated a "massive" fraud on Plaintiffs by structuring and offering bogus loans and **letters of credit** ("LOCs") to StaffAmerica.<sup>FN2</sup> Plaintiffs claim that Defendants scheme ultimately resulted in Defendants inducing BACE to sell its PEO operations to Defendant Cura,<sup>FN3</sup> a wholly owned subsidiary of Defendant Certified Services, Inc. ("Certified"). Defendants Midwest, Huff, and LBS (the "Moving Defendants") have moved to dismiss the Plaintiffs' claims against them, alleging that the court lacks personal jurisdiction over them. The Plaintiffs have responded with Affidavits and other supporting documents, which Defendants have disputed through their own affidavits.

FN2. The LOCs were required by Plaintiffs to collateralize Plaintiffs' **workers' compensation** insurance coverage.

FN3. "Defendant Cura" refers collectively to the Cura Defendants.

### **DISCUSSION**

When personal jurisdiction is disputed, the burden is on the plaintiff to prove grounds for personal jurisdiction by a preponderance of the evidence. *Carefirst of Maryland, Inc. v. Carefirst Pregnancy Centers, Inc.*, 334 F.3d 390, 396 (4th Cir.2003). Where, as here, the court decides a motion to dismiss for lack of personal jurisdiction without conducting an evidentiary hearing, the plaintiff need only make a prima facie showing of jurisdiction. *Id.* In deciding whether the plaintiff has made such a showing, the court must resolve all disputed facts and reasonable inferences in favor of the plaintiff. *Id.* In order to assert personal jurisdiction over the non-resident Defendants, two conditions must be satisfied: (1) North Carolina's long-arm statute must confer personal jurisdiction, and (2) the exercise of personal jurisdiction over the Moving Defendants must not violate the requirements of the Due Process Clause of the Fourteenth Amendment. See *Mylan Laboratories, Inc. v. Akzo, N.V.*, 2 F.3d 56, 60 (4th Cir.1993). The North Carolina Supreme Court has liberally construed the North Carolina long-arm statute to extend to the full jurisdictional powers permissible under federal Due Process. *Vishay Intertechnology, Inc. v. Delta International Corp.*, 696 F.2d 1062, 1065 (4th Cir.1982). Thus, the two-step inquiry merges into a single issue of whether the Moving Defendants have the requisite minimum contacts with North Carolina to satisfy due process. The

Supreme Court has fashioned two tests for determining whether a defendant's contacts with the forum state are sufficient to confer personal jurisdiction. If the cause of action is unrelated to the defendant's activities in the forum state, plaintiff must prove that the contacts are "continuous and systematic" to support the exercise of "general jurisdiction" over the defendant. *Helicopteros Nacionales de Colombia v. Hall*, 466 U.S. 408, 415-16 (1984). If the cause of action is related to or arises out of defendant's actions within the state, the defendant's conduct may establish more limited "specific jurisdiction." In determining whether specific jurisdiction exists, the courts consider (1) the extent to which the defendant has purposefully availed itself of the privilege of conducting activities within the state; (2) whether the plaintiff's claims arise out of those activities directed at the state; and (3) whether the exercise of personal jurisdiction would be constitutionally reasonable. *ALS Scan, Inc. v. Digital Serv. Consultants, Inc.*, 293 F.3d 707, 711-12 (4th Cir2002), *cert. denied*, 537 U.S. 1105 (2003). \*2 Plaintiffs do not contend that the Moving Defendants' contacts with North Carolina are such that the court may exercise general jurisdiction over them. Thus, the court's analysis is limited to whether specific jurisdiction exists. The court will review Plaintiffs' jurisdictional allegations as to each of the Moving Defendants. With regard to Defendant Midwest, Plaintiff alleges that Midwest was the entity responsible for obtaining LOCs to secure **workers' compensation** insurance obligations. Baumgardner Aff. ¶ 8. Plaintiffs allege that Midwest sent correspondence to the Plaintiffs in North Carolina, solicited business from Plaintiffs in North Carolina, requested and received payments from Plaintiffs in North Carolina, and sent its agents and funds to Plaintiffs' offices in North Carolina. Baumgardner Aff. ¶¶ 5-7, 9-10; Aldridge Aff. ¶¶ 11-12. Plaintiffs allege that Defendant Huff was one of the primary architects of the fraudulent scheme described in the Complaint, and represented that he, along with Defendant Pixler, "controlled" Defendants Brentwood, Certified, Cura, and Midwest. Verified Complaint ¶¶ 8, 75. Huff allegedly represented that he had the resources to provide the financing necessary for the LOCs required to collateralize Plaintiffs' **workers' compensation** insurance coverage. Verified Complaint ¶ 75. Plaintiffs allege that Huff participated in multiple meetings and conference calls (both inside and outside North Carolina) regarding the financing and procurement of the fraudulent LOCs and the overstatement of **workers' compensation** insurance premiums, all of which were allegedly designed to defraud Plaintiffs. Verified Complaint ¶¶ 38-39, 52-54, 73-78; Baumgardner Aff. ¶¶ 15, 17. Plaintiffs allege that LBS was also intimately involved in the fraudulent scheme. LBS lawyers who were representing Brentwood, Certified, and Cura during the course of the fraudulent scheme were simultaneously serving as President or CEO of Brentwood and as corporate Secretary of Certified. Verified Complaint ¶ 41; Levy Aff. ¶¶ 3, 10; Spinelli Aff. ¶¶ 2-4, 7. Many of the documents related to the fraudulent LOCs were executed by Charles Spinelli, one of the then principals and named partners of LBS, on behalf of Brentwood. Levy Aff. ¶¶ 3, 10; Spinelli Aff. ¶¶ 2-4, 7. Plaintiffs assert that LBS drafted the loan agreements that relate to the financing and procurement of the two fraudulent LOCs and sent them to North Carolina. Verified Complaint ¶¶ 40, 55; Baumgardner Aff. ¶¶ 19, 20, 22, 25-30, 33-37. Moreover, LBS drafted all the other transactional documents at issue, including the Management Agreement, the Stock Purchase Agreement and Addendum. Baumgardner Aff. ¶¶ 27-28, 34; Levy Aff. ¶¶ 6, 9; Spinelli Aff. ¶ 6. Plaintiffs allege that in August of 2002, LBS sent multiple email and faxes to Plaintiffs in North Carolina, including drafts of documents relating to the fraudulent LOCs at issue as well as wiring instructions for payments to be made to Brentwood. Baumgardner Aff. ¶¶ 20-21, 23-25. \*3 The Moving Defendants have filed affidavits and other supporting documents disputing many of the allegations mentioned above. However, as stated earlier, for purposes of these motions, the court must accept Plaintiffs' version of the

disputed facts. With that in mind, the court concludes that Plaintiffs have met their burden of making a prima facie showing of personal jurisdiction as to the Moving Defendants. The type and quantity of contacts by the Moving Defendants have been found sufficient to subject them to personal jurisdiction. See *Craco LLC v. Fiora*, No. 1:03CV676, 2004 U.S. Dist. LEXIS 5671, at \*7 (M.D.N.C. Jan. 23, 2004) (personal jurisdiction found to exist over non-resident defendant due to fact he had negotiated via “telephone or some other electronic means” with North Carolina plaintiff); *Carefirst*, 334 F.3d at 397 (“Even a single contact may be sufficient to create jurisdiction when the cause of action arises out of that single contact ...”); *Cree v. Exel N. Am. Logistics, Inc.*, No. 1:02CV319, 2004 U.S. Dist. LEXIS 1726, \*9-10 (M.D.N.C. February 6, 2004) (finding corporate defendant's purposeful availment most clearly evidenced by its solicitation of plaintiff's business in North Carolina). If Plaintiffs' allegations are taken as true, the Moving Defendants have purposefully availed themselves of the privilege of conducting activities within this state which directly relate to Plaintiff's claims. Moreover, the court finds that the exercise of personal jurisdiction over these Defendants is constitutionally reasonable. Accordingly, IT IS THEREFORE ORDERED that the Motions to Dismiss for Lack of Personal Jurisdiction filed by Defendants LBS, Midwest, and Huff are hereby DENIED.

Supreme Court of Alabama.  
CONTINENTAL CASUALTY COMPANY

v.

SOUTHTRUST BANK, N.A.

1041136.

Jan. 6, 2006.

**Background:** Letter of credit applicant brought action against issuer and beneficiary to enjoin them from honoring and drawing on the letter of credit. Beneficiary filed cross-claim to recover for refusal to honor sight draft. The Circuit Court, Tallapoosa County, No. CV-03-259, Thomas F. Young, Jr., J., entered summary judgment in favor of issuer on the cross-claim. Beneficiary appealed. **Holding:** The Supreme Court held that sight draft was proper without beneficiary's address, and, thus, issuer was required to honor it.

Skilstaf, Inc., initiated a civil action against SouthTrust Bank, N.A., and Continental Casualty Company, seeking to enjoin Continental from drawing on, and SouthTrust from honoring, a letter of credit (hereinafter "the LC"). The LC was established by SouthTrust at Skilstaf's request\*338 for the benefit of Continental. Continental filed a cross-claim against SouthTrust, alleging breach of contract, fraud, and negligence, and that SouthTrust's refusal to honor Continental's sight draft on the LC violated § 7-5-101 et seq., Ala.Code 1975. SouthTrust answered, denying that it had wrongfully refused to honor Continental's sight draft. SouthTrust and Continental each moved for a summary judgment on Continental's cross-claim. After conducting a hearing, the trial court entered a summary judgment for SouthTrust and denied Continental's motion. The trial judge certified the order as final pursuant to Rule 54(b), Ala. R. Civ. P. Continental appeals. We reverse and remand.

#### *Facts*

Skilstaf's claim arose out of **workers' compensation** insurance policies issued by Continental to Skilstaf from 1996 to 2001. Skilstaf's **workers' compensation** program was administered under certain claim-service agreements between Skilstaf and Continental. Skilstaf secured its obligations under the claim-service agreements with, among other things, the LC, which was in the amount of \$810,000, issued by SouthTrust in favor of Continental. The LC, No. 00.OD.02804, was issued on December 14, 2000. The beneficiary of the LC was "Continental Casualty Company, c/o Risk Management Group, CNA Plaza, 333 S. Wabash, Chicago, IL 60685, Attn: Contract Administration"; the account party was "Skilstaf, Inc., 860 Airport Drive, Alexander City, AL 35010." The first two paragraphs of the LC stated: "We have established this Irrevocable Letter of Credit in your favor for drawings up to U.S. \$810,000.00 effective December 14, 2000 and expiring at SouthTrust Bank, International Department, 112 North 20th Street, Birmingham, AL 35203, with our close of business on December 14, 2001. "We hereby undertake to promptly honor your sight draft(s) drawn on us, indicating our Credit No. 00.OD.02804, for all or any part of this Credit if presented at 112 North 20th Street, Birmingham, AL 35203, Attention: International Department on or before the expiration date or any automatically extended date." The LC also stated: "This credit is subject to the Uniform Customs and Practice for Documentary Credits (1993 Revision), International Chamber of Commerce, Publication No. 500...." The LC had an expiration date of December 14, 2001, but was automatically renewed each year

unless SouthTrust notified Continental at least 60 days before the expiration date that SouthTrust elected not to renew. On September 22, 2003, SouthTrust notified Continental of its election not to renew the LC beyond its expiration date of December 14, 2003. On December 10, 2003, Continental sent SouthTrust a sight draft at the address directed by the letter of credit; SouthTrust received the sight draft at 10:58 a.m. on Friday, December 12, 2003. By the sight draft Continental attempted to draw on the LC in the amount of \$810,000. The sight draft read as follows: "Pay to the order of CONTINENTAL CASUALTY COMPANY "US Dollars Eight Hundred Ten Thousand and 00/100 "To: SouthTrust Bank, N.A. " 'Drawn under the SouthTrust Bank, N.A. Letter of Credit No. 00.OD.02804 dated December 14, 2000.' "Continental Casualty Company "By: /s/ W.V. Romashko \*339 "W.V. Romashko "Vice President-Property Casualty Billing & Collections" (Capitalization in original.) The logo of Continental's parent company-"CNA"-and Romashko's telephone and facsimile numbers were also included on the sight draft. The sight draft was submitted with a cover letter to SouthTrust from Romashko, also dated December 10, the letterhead of which bore the address "CNA Plaza 29 South, Chicago, Illinois 60685-0001." The letterhead also repeated Romashko's title, telephone number, and facsimile number and listed his e-mail address. The heading to the letter contained the following reference: "Applicant: Skilstaf, Inc. Letter of Credit No.: 00.OD.02804 Draw Amount: USD \$810,000.00" In the cover letter, Romashko advised SouthTrust as follows: "Enclosed is our sight draft to effect a draw on the above referenced letter of credit. Please review the enclosed document and contact Agnes N. Domingo at [area code and telephone number] immediately, if the document is not acceptable, for any reason. "Please wire transfer the funds to:

"Account Continental  
 Name: Casualty Company  
 "Bank: JP Morgan Chase  
 Bank  
 "ABA [number provided  
 No.: in original]  
 "Account [number provided  
 No.: in original]  
 "Ref. No.: GC1210132"

On December 15, 2003, SouthTrust contacted Agnes Domingo and advised her that it would not honor the sight draft "because Continental had not included its address on the sight draft." SouthTrust requested of Ms. Domingo that "Continental submit a revised draft which included Continental's address." Continental did so, presenting a second sight draft, bearing Continental's address, to SouthTrust on December 16, 2003. However, SouthTrust refused to honor this second sight draft on the basis that it had been presented after the LC had expired on December 14, 2003. Continental submitted evidence to the trial court indicating that both before and after the presentment of the first sight draft on December 10, 2003, SouthTrust honored nearly identical sight drafts presented by Continental or one of its related entities, i.e., sight drafts bearing the name, but not the address, of the beneficiary. On March 18, 2005, the trial court issued its order, which stated: "This matter comes before the Court on Motion for Summary Judgment filed by Cross-Claim Defendant, SouthTrust Bank, and Motion for Summary Judgment filed by Cross-Claim Plaintiff, Continental Casualty Company, against Cross-Claim Defendant, SouthTrust Bank, and the Court having received argument and multiple briefs from both sides, Orders as follows: "The Court finds that there is no

genuine issue of material fact and therefore, Grants the Motion for Summary Judgment filed by SouthTrust Bank as Cross-Claim Defendant. Motion for Summary Judgment filed by Cross-Claim Plaintiff, Continental Casualty Company, against Cross-Claim Defendant, Southtrust Bank, is hereby Denied.” After the trial judge certified the March 18 order as final pursuant to Rule 54(b), Ala. R. Civ. P., Continental appealed from the summary judgment for SouthTrust and attempted to appeal from the denial of its own motion for a summary judgment.

### *Legal Analysis*

It is well established that “Alabama, with the majority of the states, follows the ‘strict compliance’ rule governing the acceptance of **letters of credit**.”... SouthTrust argues that its dishonor of the first sight draft was proper because Continental failed to state in the sight draft the full name and address of the beneficiary and, thus, failed to comply strictly with the terms and conditions of the LC. Continental stated in its sight draft that payment should be made to “Continental Casualty Company.” SouthTrust insists that Continental should have stated that payment be made to “Continental Casualty Company, c/o Risk Management Group, CNA Plaza, 333 S. Wabash, Chicago, IL 60685, Attn: Contract Administration,” because that information is the information listed under “Beneficiary” in the LC. SouthTrust alleges that Continental's failure to state this full name and address in the sight draft caused a discrepancy between the sight draft and the terms of the LC, and that this discrepancy constituted a failure to comply with Alabama's requirement of “strict compliance” with the terms of the LC. Therefore, SouthTrust contends, it was not required to honor the first sight draft. In contrast, Continental contends that the inclusion of the full name and address of the beneficiary in the sight draft was not required in order to satisfy the requirement of “strict compliance” with the terms and conditions of the LC. Also, Continental argues, SouthTrust could have resolved any ambiguities it found in the sight draft by referencing the cover letter sent contemporaneously with the sight draft. Furthermore, Continental contends that SouthTrust did not observe its standard practice because SouthTrust had honored similar sight drafts for Continental both before and after the sight draft that is in question now. Section 7-5-108(c) provides that when, as here, the basis for dishonor is a discrepancy in the presentation of the letter of credit and timely notice of the discrepancy is given, “an issuer is precluded from asserting as a basis for dishonor ... any discrepancy not stated in the notice ....” unless such discrepancy results from fraud, forgery, or expiration of the letter of credit. Although the parties argue regarding the status and significance we should accord to the “Official Comment” to § 7-5-108; the recognition that should be accorded to the additional information available to SouthTrust from the cover letter that accompanied the December 10 sight draft; the import of Alabama caselaw predating the January 1, 1998, effective date of § 7-5-101 et seq., “Uniform Commercial Code-Letter of Credit”; and the rationales and results of various cases from other jurisdictions, we conclude that the issue presented is sufficiently straightforward and circumscribed that we need determine only whether the “terms and conditions of the letter of credit” required that any sight draft presented, in order to appear “on its face strictly to comply” with those terms and conditions, include the address of the presenting beneficiary. SouthTrust argues in its brief: “Continental's entire argument rests on its mistaken belief that SouthTrust refused to honor its sight draft because it failed to include Continental's address, and that the letter of credit contained no such provision. Again, Continental's argument mischaracterizes the issue

before this Court-SouthTrust did not dishonor the sight draft presented by Continental because of a 'flaw or discrepancy' not listed in the letter of credit. Rather, SouthTrust dishonored the sight draft because the beneficiary specifically noted in the letter of credit was not the same beneficiary noted in the sight draft. A sight draft containing a name of a beneficiary different than that listed in the letter of credit certainly fails to strictly comply with the letter of credit." (SouthTrust's brief, p. 23.) Because the undisputed evidence, submitted in the form of an affidavit from Ms. Domingo and not challenged or contradicted\*342 by SouthTrust, established that the discrepancy cited by SouthTrust in its December 15, 2003, notice to Continental was that "Continental had not included its address on the Sight Draft," SouthTrust is restricted by § 7-5-108(c) from attempting to recharacterize the discrepancy stated in that notice. What are "the terms and conditions of the letter of credit" upon satisfaction of which SouthTrust committed that it would "undertake to promptly honor its payment obligation"? The LC advised Continental that (1) the LC had been established in "your favor" and would be honored upon presentation of "your sight draft(s)," (2) the sight draft had to be drawn on the SouthTrust account, (3) the sight draft had to indicate SouthTrust's letter-of-credit number 00.0D.02804, (4) the sight draft had to be for all or any part of the amount of the credit, (5) the sight draft had to be presented to SouthTrust at 112 North 20th Street, Birmingham, AL 35203, Attention: International Department, and (6) the presentation had to be on or before the original expiration date or any automatically extended expiration date. SouthTrust acknowledges that Continental's December 10 sight draft satisfied all of those terms and conditions, except for the identification of the beneficiary. Thus, the issue boils down to whether the term and condition of the LC that the beneficiary present "your sight draft" required something more than that the sight draft be from Continental. Stated differently, did the inclusion of Continental's address in its listing in the LC as "beneficiary," establish as a term and condition that any sight draft submitted by Continental include its address and specifically that same address listed on the LC. We conclude that the beneficiary was "Continental Casualty Company" and that it, as an entity, is the "your" referred to in the text of the LC. We agree with Continental's statement in its brief that "[t]he beneficiary is and was always intended to be an entity, not a destination." (Continental's brief, p. 20.) Although SouthTrust argues in its appellate brief that Continental's sight draft failed "to correctly include the complete name of the beneficiary provided in the [LC]" and that the "beneficiary specifically noted in the [LC] was not the same beneficiary noted in the sight draft" (SouthTrust's brief, p. 8, 23), the sight draft does not support those contentions. The beneficiary of the sight draft was "Continental Casualty Company," at whatever address it might be using at the time it might seek to submit a sight draft drawn on the LC. Taking SouthTrust's argument to its logical extreme, if Continental had changed its physical or mailing address in any way subsequent to its listing its address as beneficiary on the LC and before the issuance of a sight draft, in order to comply strictly with the LC in submitting a sight draft drawing against it, Continental would have to state its original, but now incorrect, address. The notice of discrepancy given Continental by SouthTrust did not state that there was any doubt or uncertainty about whether the drawer of the sight draft, "Continental Casualty Company," was the same entity as "Continental Casualty Company," the beneficiary of the LC. Rather, in contacting Ms. Domingo, which Romashko's December 10 cover letter requested SouthTrust do "if the document is not acceptable, for any reason," SouthTrust simply advised Ms. Domingo that the sight draft was not acceptable because Continental had not provided its address. Because the LC nowhere required that a sight draft drawn on it by "Continental Casualty Company" list that entity's address, we cannot hold, as a matter of law, that inclusion of an address on the sight draft was a term or condition of the LC. Accordingly, SouthTrust's motion \*343 for a summary judgment, predicated

solely on the contention that the December 10 sight draft “failed to contain the same identifying information as to [Continental] as SkilStaf’s [LC],” did not establish SouthTrust’s right to a judgment as a matter of law on Continental’s cross-claim in the case, and the summary judgment cannot be upheld.

*Conclusion*

For the reasons explained above, we reverse the summary judgment entered in favor of SouthTrust and remand this case to the trial court for further proceedings consistent with this opinion. REVERSED AND REMANDED.

Slip Copy, 2006 WL 3497318

N.D.Ill., 2006.

December 04, 2006 (Approx. 4 pages)

**FACTUAL BACKGROUND**

\*2 In March of 1997, American Patriot established a "rent-a-captive" insurance program called the Roofers Advantage Program ("the Program"). This program was marketed to American Patriot by Mutual Risk Management, Ltd. ("Mutual Risk"), Commonwealth Risk Services, L.P. ("Commonwealth Risk"), Legion, Villanova, and Mutual Indemnity (Bermuda), Ltd. ("MIB") (collectively, the "Mutual Entities"). In order to set-up the Program, American Patriot executed the following documents: (1) a Proposal provided by Commonwealth Risk; (2) a Limited Agency Agreement between Legion and American Patriot; and (3) a Shareholders Agreement between American Patriot and Mutual Holdings (Bermuda), Ltd. ("Mutual Holdings"), the parent company of MIB. Under the Program, Legion acted as an insurance company, issuing **workers' compensation** policies to roofing contractors on behalf of American Patriot. As the insurer, Legion had primary responsibility for all insured losses up to the applicable policy limits. Each year, Legion retained an Annual Aggregate Retention (10% of the gross written premium) to establish the "initial working layer" of coverage for losses and expenses under the Program. Once the losses and expenses in a Program year exceeded Legion's 10% retention, however, MIB would reimburse Legion for additional losses up to the Aggregate Attachment Point, per Reinsurance Treaty 103, using money from the net ceded premium to cover its expenses. Additionally, the Shareholders Agreement provided that American Patriot would indemnify MIB if the losses exceeded the net ceded premium, but were less than the Aggregate Attachment Point. Thus, together, MIB and American Patriot provided the "second layer" of reinsurance coverage. (Conversely, the Shareholders Agreement also allowed American Patriot to recover a profit if the net ceded premium were to exceed the Program losses.) In 1998, Diane and Kenneth Hendricks assumed American Patriot's rights and obligations under the Shareholders Agreement, retroactive to 1997. At issue in this case is the liability distribution of both parties after the Aggregate Attachment Point. Defendants claim that all amounts exceeding the Aggregate Attachment Point become the responsibility of Legion, noting that if MIB has no liability, neither American Patriot nor the Hendricks have any obligation to indemnify MIB. The Liquidator insists that, pursuant to a 1993 Amendment to Reinsurance Treaty 103, only the first \$5 million of exposure above the Aggregate Attachment Point is Legion's responsibility, which it covered through outside reinsurers. The Liquidator calls this the "third layer" of reinsurance coverage. The Liquidator claims that, pursuant to the 1993 Amendment, MIB then provided an additional "fourth layer" of reinsurance coverage up to an additional \$5 million on any one program, but not to exceed \$10 million for all programs in a given program year. Because MIB was allegedly liable to Legion for this level of coverage, the Liquidator argues that American Patriot and the Hendricks had potential exposure to this liability, as well. \*3 At this point in the proceedings, the parties dispute two basic questions: (1) whether American Patriot is liable for Program losses above the Aggregate Attachment Point, pursuant to Reinsurance Treaty 103 and related Program documents, and (2) if so, whether this liability was the result of Legion's conspiracy to defraud American Patriot and the Hendricks. In her Order of May 9, 2006, Magistrate Judge Nolan determined that these questions could and should be treated separately from one another for purposes of discovery and summary judgment. ( See Dkt. No. 83-5, "May 9, 2006 Tr."). In order to properly set the stage for Magistrate Judge Nolan's Order, however, it is first necessary to describe in more detail the Defendants' allegations of fraud and the deponents' assertion of the attorney-client privilege.

### *1. The Alleged Fraud*

Both parties agree that, in February of 2000, Saran and Diane Hendricks met with Eric Bossard ("Bossard"), Vice President of Legion, and James Agnew ("Agnew"), Vice President of Commonwealth Risk, to discuss Program renewal for the year 2000. Prior to this meeting, the Program had been experiencing increasing losses and the need for adjustments in the Program reserves. Concerned about these losses, Diane Hendricks raised questions at the February 2000 meeting about the extent of her personal exposure for **workers' compensation** losses. Defendants allege that Diane Hendricks specifically asked "whether Patriot's ultimate liability extended only to the Aggregate Attachment Point or beyond." (Defs.' Mem. at 6). In a nuanced argument, the Liquidator alleges that Diane Hendricks only asked if she was exposed to liability "further than the **letters of credit**" she had already supplied to MIB. (Pl.'s Resp. at 5). Defendants base their understanding of what transpired next on the affidavits of Bossard and Agnew. Defendants allege that, in response to Diane Hendricks' questions, Agnew and Bossard met with Richard Turner ("Turner"), President of Commonwealth Risk, and Glenn Partridge ("Partridge"), Executive Vice President of Legion, to discuss American Patriot's liability beyond the Aggregate Attachment Point. Andrew Walsh ("Walsh"), Legion's in-house counsel, allegedly joined the conversation by telephone and told the men that Legion was the entity responsible for losses in excess of the Aggregate Attachment Point. Finally, Bossard, Agnew, Turner, Partridge, Walsh and David Alexander ("Alexander"), President of MIB, then allegedly determined to cook-up a plan to amend Reinsurance Treaty 103 so as to create liability for American Patriot beyond the Aggregate Attachment Point, and to convince American Patriot and/or the Hendricks to buy \$1 million of reinsurance so as to cover this newly-created liability. Defendants allege that the conspirators never intended to buy this reinsurance, as they knew American Patriot was not liable for these losses in the first place. The Liquidator argues in response that Diane Hendricks did not rely on any statements made by Bossard and Agnew in determining that she was exposed to liability beyond the letter of credit, instead relying on the opinions of Saran, attorney Karl Leo (on American Patriot's Board of Directors), and Scott Thomas (of Patriot Underwriting, Inc.). The Liquidator also argues that the 1993 amendment to Reinsurance Treaty 103 added a fourth layer of exposure "in the amount of \$5 million per program in any one given treaty year and \$10 million for all programs for a given treaty year." (Pl.'s Resp. at 6). The Liquidator asserts that, per the 1993 amendment, MIB is responsible for this layer of coverage, thus American Patriot and the Hendricks are exposed to liability at this level. Lastly, the Liquidator argues that neither Legion nor MIB would have had anything to gain from perpetrating the alleged fraud. It is undisputed that American Patriot and the Hendricks entered into a letter agreement with MIB on April 20, 2000, thereby capping the Hendricks' liability for a provisional premium of \$480,000.

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA  
MIAMI DIVISION

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CASE NO. 02-23687

**CIV. JORDAN**

U.S. INSURANCE GROUP, LLC,  
and OWNER OPERATOR RESOURCES  
CORP.,

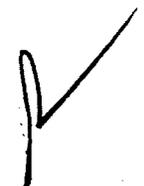
MAGISTRATE JUDGE  
: BROWN

Plaintiffs,

v.

STEVEN MARIANO, INSERVE CORP.,  
OCCUCARE USA, INC. AND TAR HEEL  
MANAGEMENT,

Defendants.

RECEIVED  
JAN 10 2003  
CIVIL DIVISION  


**COMPLAINT**

The plaintiffs, U.S. Insurance Group, LLC ("USIG") and Owner Operator Resources Corp. ("OORC") (collectively, the "Plaintiffs"), by and through their attorneys, for their complaint against the defendants Steven Mariano ("Mariano"), InServe Corp. ("InServe"), OccuCare USA, Inc. ("OccuCare") and Tar Heel Management, (collectively, the "Defendants") allege as follows:

**The Parties**

1. The Plaintiff, USIG, is an insurance agency and broker organized and existing under the laws of the State of Tennessee, with its principal place of business at 835 Georgia Avenue, Suite 500, Chattanooga, TN 37402.



2. The Plaintiff, OORC, is a third-party administrator for owner operators organized and existing under the laws of the State of Indiana, with its principal place of business at 430 Wayne Street, Angola, IN 46703.

3. The Defendant, Steven Mariano, is an individual residing in the State of Florida.

4. The Defendant, InServe Corporation, is an intermediary and a third-party administrator organized and existing under the laws of the State of North Carolina, with its principal place of business at 4401 Barclay Downs Drive, Charlotte, NC 28209.

5. The Defendant, OccuCare USA, Inc., is a company organized and existing under the laws of the State of North Carolina, with its principal place of business at 4401 Barclay Downs Drive, Charlotte, NC 28209.

6. The Defendant, Tar Heel Management, is a company organized and existing under the laws of the State of North Carolina.

7. At all times relevant hereto, there existed an agency relationship by and between the Defendants, whereby Defendant Mariano acted as the Principal with the Defendants acting by and through Defendant Mariano. In furtherance of this relationship, the Defendants acted on behalf of and through each other as set forth herein.

**Jurisdiction and Venue**

8. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1332(a) because there is complete diversity of citizenship, and the amount in controversy exceeds \$75,000, exclusive of interest and costs.

9. Venue in this Court is proper pursuant to 28 U.S.C. § 1391(a) and (c) because there is personal jurisdiction over the defendants in Florida.

**Factual Allegations**

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10. This case involves transactions that took place in the context of the captive insurance and reinsurance industry beginning in the summer of 2000 regarding a workers' compensation captive program for owner operators within the trucking industry. Reinsurance is a transaction whereby an insurance company (known as the "reinsurer"), in exchange for a premium, agrees to indemnify or reimburse another insurance company (known as the "ceding company," "cedent" or "reinsured") against all or part of a loss the ceding company may sustain under insurance policies it has issued. Reinsurance arrangements are common among insurers. By purchasing reinsurance -- by "ceding" part of the risk -- insurers may effectively expand their capital capacity, ameliorate the impact of large losses and spread the concentration of risk.

11. "Captive" insurance is utilized by insureds that choose to put their own capital at risk by creating their own insurance company outside of the traditional commercial insurance marketplace. The purchase of captive insurance requires the insured, or a party affiliated with or connected to the insured, to be both willing and able to contribute risk capital. To determine whether to participate in a captive structure, an insured must analyze its risk financing options and have the financial wherewithal to invest its own resources to benefit from this type of risk financing program.

12. In the summer of 2000, the Defendant Mariano, acting in his own capacity and by and through OccuCare, formed a captive with a domestic stock insurance company, the New York-based Clarendon National Insurance Company ("Clarendon"), fronting the program for the Bermuda-based captive reinsurer Princeton Eagle Insurance Company Limited (hereinafter, the "Captive"). In a fronting arrangement, one insurance company (the "fronting" company) issues a policy on behalf of another insurer. Up to 100 percent of the risk is then ceded to the other

insurer, often a reinsurer, which is an insurance company (oftentimes, a non-U.S. based insurance company) not licensed to issue policies directly to insureds. The captive reinsurance company pays losses incurred under the front company policy.

13. On or about November of 2000, Mariano, acting in his own capacity and by and through the Defendants, sought outside investors to contribute to the Captive. Defendant Mariano asked the Plaintiffs, OORC and USIG, and non-party Ralph Royster ("Royster"), President and CEO of RDR Corporation and registered agent for InServe, to invest in the Captive.

14. In order to induce the Plaintiffs to invest in the Captive, Defendant Mariano, acting by and through the Defendants, represented that the Plaintiffs were investing in a protected cell within a segregated accounts captive as opposed to a pure group captive. In a sponsored segregated accounts captive, the insured's risk capital is typically only exposed to the risk of its own underwriting performance. Conversely, a member or owner in a pure group captive shares risk with the other captive insureds. This means that insureds who are shareholders or members of the industrial insured group captive not only have to contribute capital to access the captive insurance program, but their capital is at risk based on the performance of the group as a whole.

15. Prior to forming the captive, and in order to further induce the Plaintiffs to invest in the Captive, Defendant Mariano, acting by and through the Defendants, represented that a \$100 per month per driver premium produced profitable results in the trucking insurance industry, and that in order to produce profitable results for the Captive, the minimum commercial trucking insurance policy premium would be \$125 per month per driver. Plaintiffs reasonably relied on these figures as represented by Mariano to invest in the Captive and to justifiably and

reasonably expect a profitable return, based upon Defendant Mariano's expertise and representations that he was knowledgeable in the area of captive programs, and Plaintiffs' lack of knowledge regarding captive programs. The Defendant, Mariano, by and through the Defendants, further represented to the Plaintiffs that the expenses of the Captive would be no more than 28.6% of the \$6,000,000 premium. During a November 2000 meeting, and upon information and belief, Defendants represented that no change would be made in pricing unless approved by a majority vote of the Captive shareholders. At this point, Defendant Mariano also represented that he was planning to purchase accidental death and dismemberment ("AD&D") coverage. Upon information and belief, Defendant purchased AD&D coverage only after the Captive experienced significant losses.

16. Upon information and belief, and in order to further induce Plaintiffs to invest in the Captive, Defendant Mariano, acting by and through the defendants, further represented that the fees for managing the Captive would only be \$36 of the \$125 premium, and additionally, that the fees would include reinsurance costs, InServe costs and fees and brokers fees.

17. At the Defendants' request, and based upon the representations outlined above, USIG invested in the Captive and furnished an irrevocable letter of credit to Clarendon ("LOC") in the amount of \$340,000, and OORC invested in the Captive and furnished a LOC to Clarendon in the amount of \$510,000. Upon information and belief, Defendants furnished a LOC totaling only \$1,000,000. As a result of the investments, the percentage of ownership in the Captive was as follows:

Mariano:	45%
OORC:	30%
USIG:	20%
Royster (RDR Corp.):	5%

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18. Subsequent to USIG and OORC investing in the Captive and providing LOCs to Clarendon, despite Plaintiffs repeated requests, the Defendants refused to provide the following information and documentation, even though this information and documentation was integral to the Plaintiffs' future evaluation of whether to post additional LOCs for the Captive: (1) confirmation of Defendant Mariano's LOC and vendor agreements with Mariano's companies regulating all of Mariano's programs; (2) confirmation of any vendor agreements between 3<sup>rd</sup> parties and the segregated accounts captive; (3) confirmation of any shareholder agreement; (4) confirmation of any operating agreement; (5) confirmation of any actuarial study or feasibility study; and (6) a copy of any audited financial statements.

19. After not receiving the requested information and documentation, Plaintiffs learned that they had not invested in a protected cell within a segregated accounts captive as the Defendant Mariano, acting by and through the Defendants, had represented prior to their issuing the LOCs, but rather, USIG and OORC were part of an \$80,000,000 captive between Clarendon and OccuCare, wherein each insured shareholder shares the underwriting risk of each insured within the Captive. The captive program between Clarendon and OccuCare is memorialized in the Workers' Compensation Insurance General Agency Agreement, entered into on September 21, 2000 and effective September 1, 2000, prior to USIG's and OORC's issuance of the LOCs.

20. Shortly thereafter, on or about December of 2000, New Prime, a trucking firm, purchased several insurance policies from the Captive. Following the addition of New Prime as an insured, the Captive incurred significant losses. Between January of 2001 and May of 2001, New Prime submitted the following claims: (1) January: 14 claims (\$662,327.64 losses incurred); (2) February: 27 claims (\$370,100.07 losses incurred); (3) March: 25 claims (\$345,506.00 losses incurred); (4) April: 41 claims (\$418,171.64 losses incurred); (5) May: 12

claims (\$17,300.00 losses incurred). Upon information and belief, had Defendant Mariano, as represented to Plaintiffs, purchased AD&D coverage prior to adding New Prime as a client, the Captive's losses would have been significantly less.

21. Although Plaintiffs justifiably and reasonably relied on the Defendants' representations that the commercial trucking insurance policy premium would be \$125 per month, Defendants announced in March of 2001 that New Prime's 2700 drivers were to be re-priced at \$175 per driver per month as opposed to \$145 per driver per month. Defendants later announced that the InServe fees would be increased from the initially represented \$36 to \$43 per client per month in order to deflect Mariano's increased risk exposure. Upon information and belief, this \$43 fee was excessive, leaving only \$82 net premium to pay claims and purchase reinsurance. Defendant Mariano further represented that every additional rate increase would be directed to a premium fund, which fund was to be made available to subsidize underwriting losses related to the Captive. Upon information and belief, this fund was never made available to subsidize underwriting losses, but rather, was siphoned off to Defendant Mariano by and through InServe. At this juncture, Defendants requested that Plaintiffs post additional LOCs.

22. Since then, Plaintiffs have made repeated demands for financial statements regarding the Captive prior to furnishing additional LOCs.

23. Plaintiffs have been required to retain undersigned counsel to represent them in this matter and have agreed to pay such firm a reasonable fee for its services.

**Count I**  
**Intentional Misrepresentation**

24. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

25. Defendants made affirmative representations of material fact to Plaintiffs OORC and USIG that they were investing in a protected cell within a segregated accounts captive prior to OORC and USIG agreeing to furnish LOCs to finance the Captive, and that the premium would be \$125 per driver per month.

26. The Defendants' affirmative representations of material fact to OORC and USIG that they were investing in a protected cell within a segregated accounts captive, were false. As it turned out, USIG and OORC were really part of an \$80,000,000 pure captive between Clarendon and OccuCare, acting by and through Defendant Mariano, whereby each shareholder insured within the captive shares the underwriting risk of the other captive insureds.

27. Defendants permitted, encouraged and induced OORC and USIG to furnish LOCs with knowledge and reckless disregard of the above factual misrepresentations.

28. The Plaintiffs, USIG and OORC, in justifiable reliance on Defendants' intentional misrepresentations of material fact and upon Defendant Mariano's representations that he was knowledgeable in the area of captive programs, furnished respectively an irrevocable \$340,000 and \$510,000 LOC in order to finance what they were intentionally led to believe was a protected cell within a segregated accounts captive.

29. As a result of the Plaintiffs' justifiable reliance on Defendants' intentional misrepresentations of material fact, USIG and OORC suffered losses in the amount of the LOCs that they furnished to Clarendon.

30. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of the Defendants' intentional misconduct.

**Count II**  
**Fraud**

31. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

32. Defendants made affirmative representations of material fact to Plaintiffs OORC and USIG that they were investing in a protected cell within a segregated accounts captive prior to OORC and USIG agreeing to issue LOCs to finance the Captive, and that the premium would be \$125 per driver per month.

33. The Defendants' affirmative representations of material fact to OORC and USIG that they were investing in a protected cell within a segregated accounts captive, were false. As it turned out, USIG and OORC were really part of an \$80,000,000 pure captive between Clarendon and OccuCare, whereby each shareholder insured within the captive shares the underwriting risk of the other captive insureds.

34. Defendants permitted, encouraged and induced OORC and USIG to furnish LOCs with knowledge and reckless disregard of the above factual misrepresentations.

35. The Plaintiffs, USIG and OORC, in reasonable reliance on Defendants' intentional misrepresentations of material fact and Defendant Mariano's representations that he was knowledgeable in the area of captive programs, furnished respectively an irrevocable \$340,000 and \$510,000 LOC in order to finance what they were intentionally led to believe was a protected cell within a segregated accounts captive.

36. As a result of the Plaintiffs' reasonable reliance on Defendants' intentional misrepresentations of material fact, USIG and OORC suffered losses in the amount of the LOCs that they furnished to Clarendon.

37. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of the Defendants' intentional and fraudulent misconduct.

**Count III**  
**Negligent Misrepresentation**

38. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

39. Defendant Mariano, acting by and through the Defendants on behalf of the Captive in which Defendants maintained a pecuniary interest, through the Defendants' failure to exercise reasonable care or competence in transacting the business of the Captive, supplied false information to Plaintiffs OORC and USIG that they were investing in a protected cell within a segregated accounts captive prior to OORC and USIG agreeing to furnish LOCs to finance the Captive, and that the premium would be \$125 per driver per month.

40. Defendant Mariano, acting by and through the Defendants, knew or reasonably should have known that the above representations were false, and that Plaintiffs would act in actual reliance on the representations provided.

41. In justifiable and actual reliance on the Defendants' representations, Plaintiffs USIG and OORC issued respectively, irrevocable \$340,000 and \$510,000 LOCs in order to finance what they were negligently led to believe was a protected cell within a segregated accounts captive.

42. As a result of the Plaintiffs' reasonable and actual reliance on Defendants' negligent misrepresentations of material fact, Defendants caused USIG and OORC to suffer losses in the amount of the LOCs that they furnished to Clarendon.

43. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of the Defendants' negligent conduct.

**Count IV**  
**Innocent Misrepresentation**

44. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

45. Defendant Mariano, acting by and through the Defendants on behalf of the Captive in which Defendants maintained a pecuniary interest, through the Defendants' failure to exercise reasonable care or competence in transacting the business of the Captive, supplied false information to Plaintiffs OORC and USIG that they were investing in a protected cell within a segregated accounts captive prior to OORC and USIG agreeing to furnish LOCs to finance the Captive, and that the premium would be \$125 per driver per month.

46. Defendant Mariano, acting by and through the Defendants, knew or reasonably should have known that Plaintiffs would act in actual reliance on the material so provided.

47. In justifiable and actual reliance on the Defendants' representations, Plaintiffs USIG and OORC issued respectively, irrevocable \$340,000 and \$510,000 LOCs in order to finance what they were negligently led to believe was a protected cell within a segregated accounts captive.

48. As a result of the Plaintiffs' justifiable reliance on Defendants' negligent misrepresentations of material fact, USIG and OORC suffered losses in the amount of the LOCs that they furnished to Clarendon.

49. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of the Defendants' negligent conduct.

**Count V**  
**Unfair and Deceptive Trade Practices Under Florida Law**

50. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

51. Florida Statutes Section 501.201 et seq., provides a plaintiff a private cause of action for deceptive or unfair trade practices in the conduct of any trade or commerce. Under Florida law, "unfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce are declared unlawful." See Fla. Stat. §§ 501.24 – 501.211.

52. Defendants have violated Fla. Stat. § 501.24 in the following ways:

- (a) Defendants have engaged in unfair or deceptive acts by falsely representing to the Plaintiffs that the Captive was a protected cell captive, and that the Plaintiffs' risks were limited to their own investment in the Captive, in order to induce Plaintiffs to invest in the Captive in the course of conducting the trade or business of the Captive, where Defendants knew or reasonably should have known that the Captive was not a protected cell captive; and
- (b) Defendants' unfair or deceptive acts in falsely representing to the Plaintiffs that the Captive was a protected cell captive as opposed to a pure group captive in order to induce Plaintiffs to invest in the Captive, are offensive

to public policy, immoral, unethical, oppressive, unscrupulous and <sup>89</sup>  
substantially injurious to the Plaintiffs.

53. Upon information and belief, Defendants have engaged in a pattern and practice of unfair or deceptive acts by falsely representing the nature of their captive Program.

54. As a result of Defendants' unfair or deceptive trade practices committed in the course of the trade or business of the Captive, Plaintiffs have been and continue to be actually aggrieved.

55. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of Defendants' unfair or deceptive trade practices.

**Count VI**  
**Unfair and Deceptive Trade Practices Under Indiana Law**

56. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

57. Indiana Code Section 24-5-0.5-3 et seq., provides a plaintiff a private cause of action for unfair or deceptive trade practices, if a defendant, either orally or in writing, represents that the subject of a consumer transaction "has sponsorship, approval, performance, characteristics, accessories, uses or benefits it does not have which the supplier knows or should reasonably know it does not have." Burns Ind. Code Ann. §§ 24-5-0.5-3 – 24-5-0.5-4.

58. Defendants have violated § 24-5-0.5-3 et seq., in the following ways:

- (a) Defendants have engaged in unfair or deceptive acts by falsely representing to the Plaintiffs that the Captive was a protected cell captive, and that the Plaintiffs' risks were limited to their own investment in the Captive, in order to induce Plaintiffs to invest in the Captive in the course

of conducting the trade or business of the Captive, where Defendants<sup>90</sup> knew or reasonably should have known that the Captive was not a protected cell captive; and

- (b) Defendants' unfair or deceptive acts in falsely representing to the Plaintiffs that the Captive was a protected cell captive as opposed to a pure group captive in order to induce Plaintiffs to invest in the Captive, are offensive to public policy, immoral, unethical, oppressive, unscrupulous and substantially injurious to the Plaintiffs.

59. Upon information and belief, Defendants have engaged in a pattern and practice of unfair or deceptive acts by falsely representing the nature of their captive Program.

60. As a result of Defendants' unfair or deceptive trade practices committed in the course of the trade or business of the Captive, Plaintiffs have been and continue to be actually aggrieved.

61. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of Defendants' unfair or deceptive trade practices.

**Count VII**  
**Unfair and Deceptive Trade Practices Under North Carolina Law**

62. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

63. North Carolina General Statutes Section 75-1.1 et seq., provides a plaintiff a private cause of action for unfair or deceptive trade in or affecting commerce, including all business activities.

64. Defendants have violated Section 75-1.1 et seq., in the following ways:

- 91
- (a) Defendants have engaged in unfair or deceptive acts by falsely representing to the Plaintiffs that the Captive was a protected cell captive, and that the Plaintiffs' risks were limited to their own investment in the Captive, in order to induce Plaintiffs to invest in the Captive in the course of conducting the trade or business of the Captive, where Defendants knew or reasonably should have known that the Captive was not a protected cell captive; and
- (b) Defendants' unfair or deceptive acts in falsely representing to the Plaintiffs that the Captive was a protected cell captive as opposed to a pure group captive in order to induce Plaintiffs to invest in the Captive, are offensive to public policy, immoral, unethical, oppressive, unscrupulous and substantially injurious to the Plaintiffs.

65. Upon information and belief, Defendants have engaged in a pattern and practice of unfair or deceptive acts by falsely representing the nature of their captive Program.

66. As a result of Defendants' unfair or deceptive trade practices committed in the course of the trade or business of the Captive, Plaintiffs have been and continue to be actually aggrieved.

67. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of Defendants' unfair or deceptive trade practices.

**Count VIII**  
**Unfair and Deceptive Trade Practices Under Tennessee Law**

68. The Plaintiffs re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 23 herein.

69. Tennessee Code Annotated Section 47-18-101 et seq., provides a plaintiff a private cause of action for unfair or deceptive trade practices. See Tenn. Code Ann. § 47-18-109.

70. Defendants have violated § 47-18-101 et seq., in the following ways:

- (a) Defendants have engaged in unfair or deceptive acts by falsely representing to the Plaintiffs that the Captive was a protected cell captive, and that the Plaintiffs' risks were limited to their own investment in the Captive, in order to induce Plaintiffs to invest in the Captive in the course of conducting the trade or business of the Captive, where Defendants knew or reasonably should have known that the Captive was not a protected cell captive; and
- (b) Defendants' unfair or deceptive acts in falsely representing to the Plaintiffs that the Captive was a protected cell captive as opposed to a pure group captive in order to induce Plaintiffs to invest in the Captive, are offensive to public policy, immoral, unethical, oppressive, unscrupulous and substantially injurious to the Plaintiffs.

71. Upon information and belief, Defendants have engaged in a pattern and practice of unfair or deceptive acts by falsely representing the nature of their captive Program.

72. As a result of Defendants' unfair or deceptive trade practices committed in the course of the trade or business of the Captive, Plaintiffs have been and continue to be actually aggrieved.

73. The Plaintiffs, USIG and OORC, have incurred and will continue to incur significant legal costs in prosecuting this matter, all as a consequence of Defendants' unfair or deceptive trade practices.

WHEREFORE, the Plaintiffs, U.S. Insurance Group, LLC and Owner Operator Resources Corporation pray for judgment and order of this Court against the Defendants, Steven Mariano, InServe Corp., OccuCare USA, Inc., and Tar Heel Management, as follows:

- (a) Compensatory damages equivalent to the economic value of the LOCs that the Plaintiffs furnished;
- (b) Punitive damages as a result of Defendants' fraudulent and intentional misrepresentations of material fact, and Defendants' pattern or practice of unfair or deceptive trade practices in conducting the business of the Captive;
- (c) Legal and other costs associated with the prosecution of this matter;
- (d) Interest; and
- (e) Such other and further relief as this Court may deem just and proper.

**DEMAND FOR JURY TRIAL**

Plaintiffs demand a jury trial for all issues so triable.

U.S. INSURANCE GROUP, LLC and  
OWNER OPERATOR RESOURCES,  
CORP.

By their attorneys



EDWARDS & ANGELL, LLP

Gary A. Woodfield

Florida Bar No. 563102

One North Clematis Street, Suite 400

West Palm Beach, FL 33401

Telephone: (561) 833-7700

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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION  
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DEPUTY CLERK  
WESTERN DISTRICT OF MICH

BY \_\_\_\_\_

UNITED STATES OF AMERICA,

Plaintiff,

No.

1 : 07 CR 0036

vs.

Hon.

**Gordon J. Quist**  
**U.S. District Judge**

RICHARD M. ROSENBAUM,  
EDWARD SCOTT CUNNINGHAM,  
CHRISTINA A. FLOCKEN,

Defendants.

**INDICTMENT**

\_\_\_\_\_  
The Grand Jury charges:

**INTRODUCTION**

At all times pertinent hereto, the following relevant facts were true:

1. On June 19, 1997, Richard M. Rosenbaum and Edward Scott Cunningham (Scott Cunningham), then residents of the State of Florida, caused articles of incorporation to be filed in the Office of the Nevada Secretary of State for a corporation named "Rosenbaum-Cunningham International, Inc." (RCI). The incorporation documents of this business established that its board of directors consisted solely of Rosenbaum and Cunningham; specified an address in Palm Beach, Florida as the principal business office; and named Rosenbaum as "President" and Cunningham as "Secretary/Treasurer." The documents also authorized the issuance of 25,000 shares of stock valued at \$1.00 apiece and recorded the sale of 500 such shares to both Rosenbaum and Cunningham. Rosenbaum and Cunningham then completed and caused to be filed a Nevada Business Registration form that described the nature of their business as a "janitorial contracting service"; they also completed and caused to be filed an application for RCI

to transact business in the State of Florida.

2. On November 3, 1997, Rosenbaum, Cunningham, and Christina A. Flocken opened a bank account with Nations Bank under the corporate name "RCI Inc." and titled "RCI Inc. Payroll Account." Rosenbaum signed the account signature card as "President," Cunningham signed as "Vice President," and Flocken signed as "Controller."

3. Prior to incorporating under the name "Rosenbaum-Cunningham International" in Nevada, Rosenbaum had, since at least 1993, operated a janitorial cleaning service that catered to the theme restaurant industry under the name "Rose Cleaning." Cunningham joined the enterprise during that period, and Flocken acted as the bookkeeper and accountant.

4. Operating RCI from June 1997 to January 2007, Rosenbaum, Cunningham, and Flocken expanded their client list to include major national restaurant chains such as "House of Blues," "Planet Hollywood," "Dave and Busters," "Hard Rock Café," "ESPN Zone," "China Grill," and "Yardhouse." In October 1999, Rosenbaum also contracted with the Grand Traverse Resort (the Resort), located in Acme, Michigan, to provide laborers for grounds and maintenance services, kitchen cleaning, and housekeeping duties.

5. The contract between the Grand Traverse Resort and Rosenbaum, doing business as RCI Inc., was renewed without change on a monthly basis until 2005, when another contract with minor modifications was negotiated. That contract was renewed in January 2006 and remained in force until it was terminated by the Resort on March 2, 2006. Like almost all of the contracts between RCI and its largest client businesses throughout the United States, the contract with the Resort specified that RCI was an independent contractor; that the laborers were RCI employees, hired and trained by RCI and subject to being fired at RCI's discretion; that RCI was responsible for paying the employees and for collecting, reporting, and paying Federal

employment taxes; and that RCI was responsible for complying with the requirements of the Immigration and Nationality Act relative to its employees. In return for services performed by RCI employees, the Resort paid significant sums of money directly to RCI on a weekly basis. From 2002 to 2006 alone, the Resort paid RCI approximately \$3,026,001.00 for RCI's services.

6. Between June 1997 and February 15, 2007, Rosenbaum, Cunningham, and Flocken developed, maintained, and managed a workforce of hundreds of employees working at hospitality-sector venues throughout the United States, including the Resort. Most of these employees were Mexican, Honduran, and Guatemalan nationals, and most of them were in the United States unlawfully. RCI laborers at each venue were supervised by an on-site manager; those managers typically spoke both English and Spanish, and most of them were illegal aliens themselves. At the height of RCI's operation, there were approximately 115 such on-site managers; they were responsible for ensuring that services for which the venues had contracted were performed properly, and they also paid the RCI crews in cash on a weekly basis. The managers obtained this cash by withdrawing funds that Flocken wire-transferred to bank accounts that they had opened, in their names, expressly for that purpose when they were appointed as managers.

7. As equal owners of RCI, Rosenbaum and Cunningham managed these crews through seven or more RCI supervisors who routinely traveled around the United States to resolve problems at RCI venues and, at times, to mediate with management at these venues. Some of these supervisors also managed the RCI work crews at the largest venues. Unlike most of the on-site managers, however, these supervisors were United States citizens. With few, if any, exceptions, the supervisors selected the on-site managers on criteria that included language ability and whether the person possessed a driver's license that would enable him or her to open a

bank account through which RCI payroll could be funneled. As the controller, Flocken managed RCI's finances. She billed the venues for services performed by RCI employees; received payments for those services; wire-transferred funds to bank accounts of RCI's on-site managers and supervisors for payment of RCI employees' wages; and reimbursed those managers and supervisors for non-payroll business expenses.

8. The practice of paying RCI laborers in cash was dictated by Rosenbaum and Cunningham. RCI employees were not provided with Form W-2 Wage and Tax Statements because neither Rosenbaum, Cunningham, nor Flocken prepared such statements or caused them to be prepared. Also, neither Rosenbaum, Cunningham, nor Flocken ever collected, accounted for, or paid over Federal income tax withholding, Social Security and Medicare taxes (FICA), or Federal unemployment taxes – referred to collectively as “Employment Taxes” in the Internal Revenue Code – to the Internal Revenue Service for the wages earned by any of these employees.

9. Between tax years 2001 and 2005, RCI received gross receipts from its clients, including the Resort, of approximately \$54,327,845.00. As a direct result of RCI's deliberate failure to collect, account for, and pay over the noted taxes to the Internal Revenue Service, the United States Government was deprived of approximately \$18,640,345.00 in employment taxes. As a direct result of RCI's deliberate failure to collect, account for, and pay over the noted taxes to the Internal Revenue Service, RCI was unlawfully enriched by \$18,640,345.00. The Defendants expended approximately 63 percent of these funds to pay RCI's operating expenses, and divided the remaining excess funds of approximately 37 percent among themselves.

10. In order to further disguise the true nature of their activities and to obstruct the Internal Revenue Service from performing its Government functions, Rosenbaum, Cunningham, and Flocken created several shell companies – “Ricurt Inc.,” “Sunchaser Service Corporation,”

and “Monker LLC” – and opened bank accounts in the names of these entities to hold the excess funds. Rosenbaum and Cunningham each maintained a Sunchaser account into which proceeds from RCI were transferred, and then drew on these accounts to pay personal expenses.

Rosenbaum and Flocken also used the Monker LLC and Ricurt accounts as vessels to hold illegal proceeds until they were later invested or spent. Neither Rosenbaum, Cunningham, nor Flocken ever paid any personal or corporate tax on the excess wages diverted into the Ricurt, Sunchaser, or Monker accounts. Instead, they used these funds to buy luxury boats and vehicles; to purchase lavish homes in Florida and California; to acquire race horses and to pay for their maintenance; to pay college tuition for their respective children; to fund excessive insurance policies; and generally to support extravagant spending and lifestyle costs. In a further effort to impede and obstruct the Internal Revenue Service, the Defendants also titled assets in the name of Sunchaser and Monker LLC in order to conceal the fact that Rosenbaum, Cunningham, and/or Flocken were the true owners of the assets.

11. As stated, from June 1997 and continuing to February 15, 2007, the majority of the laborers who received wages from RCI in return for performing services under RCI contracts were aliens who had entered, or remained in, the United States in violation of law. These laborers were generally hired through word-of-mouth, as a result of references from current RCI employees, and through advertisements at job fairs, Hispanic festivals, and Spanish-language newspapers. With few, if any, exceptions, the laborers were never required by Rosenbaum, Cunningham, Flocken, nor any RCI employee acting at their direction to complete job applications; to complete Form W-4 Employee Withholding Allowance Certificates; to fill out Form I-9 Employment Eligibility Verification forms; or to produce any proof either that they were United States citizens or, if aliens, that they were legally present in the United States.

Neither Rosenbaum, Cunningham, nor Flocken maintained any form of personnel records on these laborers, nor did any of RCI's supervisors. In many cases, however, Rosenbaum, Cunningham, and Flocken knew that particular employees or groups of employees were illegal aliens, and in all other cases they acted with reckless disregard that particular employees and groups of employees were illegal aliens.

12. Commencing in 1999 and continuing until March 2006, when the Resort terminated its contract with RCI, Rosenbaum and Cunningham knew that almost all of the RCI employees at the Resort were illegal aliens because they had been informed of this fact by the three persons, known to the Grand Jury, who had acted consecutively as RCI supervisors at the Resort from October 1999 until March 2006. Commencing in November 2003, if not earlier, Flocken also knew that RCI's workforce at the Resort consisted predominantly of illegal aliens. She knew this because, between November 11 and November 13, 2003, the supervisor of RCI's workforce at the Resort had obtained fraudulent Permanent Resident Cards ("Green Cards") for the majority of the workforce in order to satisfy the recent demand by Resort management that RCI demonstrate that its alien employees were lawfully present in the United States. This RCI supervisor, a person known to the Grand Jury, obtained the cards at a cost of \$3,460.43, and submitted an itemized reimbursement request to Flocken, along with a note stating that Rosenbaum had promised him an extra \$1000.00 for completing this task. On November 17, 2003, Flocken wire-transferred \$4,460.43 from RCI's Nations Bank account in Florida to a bank account of the RCI supervisor to reimburse and reward him for obtaining the fraudulent Green Cards.

13. The Grand Jury incorporates into Count 1, specifically and by reference and is if stated therein, the allegations and assertions stated in the Introduction.

**COUNT 1**

(Conspiracy To Defraud the United States and To Harbor Illegal Aliens)

Beginning in or about October 1999 and continuing until the date of this Indictment, in the Southern Division of the Western District of Michigan, and elsewhere, the Defendants,

RICHARD M. ROSENBAUM,  
EDWARD SCOTT CUNNINGHAM, and  
CHRISTINA A. FLOCKEN,

did unlawfully, willfully, and knowingly conspire, confederate and agree with one another, and with others known and unknown to the Grand Jury: (1) to defraud the United States by impeding, impairing, obstructing, and defeating the lawful Government functions of the Internal Revenue Service of the Treasury Department in the ascertainment, computation, assessment, and collection of the revenue: to wit, Federal income tax withholding, Social Security and Medicare taxes (FICA), and Federal unemployment taxes; and (2) for the purpose of commercial advantage and private financial gain, to conceal, harbor, and shield from detection more than 100 aliens, knowing and in reckless disregard of the fact that the aliens had come to, entered, or remained in the United States in violation of law.

**OBJECT AND MEANS OF THE CONSPIRACY**

The object of the conspiracy was for the Defendants to defraud the United States by concealing from the Internal Revenue Service the existence of the employment relationship between RCI and its employees in order to evade their obligation to collect, account for, and pay over significant Federal income taxes, Social Security and Medicare taxes (FICA), and Federal unemployment taxes that were due and payable on the wages paid to RCI employees throughout the United States, and in order to evade their obligations to pay their personal income taxes by

concealing the source, amount, and disposition of funds that they diverted from RCI for their own use and enjoyment. The Defendants intended to unlawfully enrich themselves in this way by establishing, maintaining, and managing an unskilled labor force of employees, knowing and in reckless disregard of the fact that most of those employees were aliens who had come to, entered, and resided in the United States in violation of law. The Defendants adopted this as a means because the composition of RCI's workforce was essential to the success of their scheme. Illegal aliens were willing to be paid in cash, without the creation of payroll records; they could be hired on the spot, without the creation of any employment records, and could be fired at will without likely legal recourse; and they were highly unlikely to report the irregular nature of their employment to any authority. The Defendants further intended to deliberately fail to collect, account for, or pay over Federal income tax withholding, Social Security and Medicare taxes (FICA), and Federal unemployment taxes to the Internal Revenue Service from the wages they paid to these employees as they were required by law to do; to expend a portion of these unlawfully retained funds on operating costs for RCI; and to retain the balance as profit for RCI, which they would then divide among themselves.

#### **OVERT ACTS**

In furtherance of the conspiracy, and to effect its objects, at least one of the following overt acts was committed in the Western District of Michigan by a member of the conspiracy.

1. Between November 11, 2003 and November 13, 2003, at the direction and with the knowledge of the Defendants, the RCI supervisor at the Resort, a person known to the Grand Jury, obtained 20 fraudulent Permanent Resident Cards ("Green Cards") in Grand Rapids, Michigan, for RCI employees at the Resort. On November 17, 2003, Flocken paid the supervisor

\$4,460.43 by bank wire-transfer to reimburse him for the cost of obtaining the cards and to reward him with an extra \$1000.00 for performing that task.

2. On or about May 20, 2004, Cunningham, with the approval of Rosenbaum and at his direction, purchased a residential property located at 7865 Shippy Road, Fife Lake, Michigan 49633 for \$129,700.00, to be used as housing for RCI employees who worked at the Resort.

3. On or about June 12, 2004, with the approval of Rosenbaum and Cunningham and at their direction, the RCI supervisor at the Resort, a person known to the Grand Jury, purchased a 1998 Ford Econoline E250 van for approximately \$3,000.00, to be used for transporting RCI employees between the Shippy Road property and the Resort.

4. On or about November 19, 2004, Rosenbaum and Cunningham met in Traverse City, Michigan with a representative of the U.S. Department of Labor (DOL), Wage and Hour Division, concerning the results of a recent DOL investigation which had concluded that RCI employees at the Resort had collectively been deprived of approximately \$95,000.00 in overtime and holiday pay and that RCI had violated the Fair Labor Standards Act. In that meeting, Rosenbaum and Cunningham admitted that RCI was responsible for the back-wages, and agreed to pay the employees. Although Rosenbaum and Cunningham did thereafter issue pay checks for the approximately 100 affected current and former employees and cause roughly half of those checks to be mailed to the DOL investigator in Traverse City in late December 2004, the checks were drawn for amounts that reflected gross pay due less deductions for Federal employment taxes. In correspondence that accompanied the checks mailed to DOL, the Defendants falsely claimed that the deductions from the amounts due reflected employment tax collection by RCI, when in fact Rosenbaum, Cunningham, and Flocken simply kept the deducted funds for

themselves. The remaining half of the checks for former employees were mailed to addresses in Mexico.

5. Beginning in or about October 1999 and continuing on a weekly basis until in or about March 2006, in or near Traverse City, Michigan, three consecutive RCI supervisors, all persons known to the Grand Jury, paid wages in cash to RCI employees for services performed at the Grand Traverse Resort. On the frequent occasions when the payroll exceeded the sum of \$10,000.00, the supervisors, with few, if any, exceptions, withdrew the sum in consecutive increments of less than \$10,000.00. The supervisors structured transactions in this manner at the direction of Rosenbaum, Cunningham, and Flocken in order to prevent the financial institution from filing the reports and maintaining the records that are required by law and regulation for cash transactions in excess of \$10,000.

6. During about October 1999, February 2005, and January 2006, at the Resort in Acme, Michigan, Rosenbaum negotiated, and subsequently executed, contracts between the Resort and RCI that provided for RCI to perform services at the Resort. These contracts stated explicitly that RCI was responsible for collecting, reporting, and paying over all applicable Federal employment taxes for its employees, and that RCI was also responsible for ensuring compliance with the Immigration and Nationality Act relative to its employees. When he negotiated these contracts, Rosenbaum knew that neither he, Cunningham, Flocken, nor any other person acting on their behalf intended to collect, account for, or pay over any required employment taxes or to ensure compliance with the Immigration and Nationality Act. In fact, he knew that the exact opposite was true.

7. On or about April 14, 2005, in Grand Traverse County, Michigan, and consistent

with a ruse developed by Defendants to prevent the Internal Revenue Service from discovering RCI's status as the direct employer of the RCI workers at the Resort, the RCI supervisor at the Resort, a person known to the Grand Jury, submitted a corporate Federal income tax return which stated that, during tax year 2004, he had operated as an independent company called "Shockeye, Inc.," had received gross income of \$765,362, and had paid \$659,316 in contract labor expenses. The supervisor knew that this was false because "Shockeye, Inc." was only a conduit through which RCI paid its employees, and that the claimed contract labor expenses of \$659,316 in fact represented salary paid, through him, by RCI to its employees.

8. The Grand Jury incorporates by reference the allegations contained in Counts 3 through 22 of this Indictment as though fully set forth herein.

18 U.S.C. § 371

8 U.S.C. § 1324(a)(1)(A)(iii)

**COUNT 2**  
(Harboring Illegal Aliens)

Between about February 2002 and about March 2006, in Grand Traverse County in the Southern Division of the Western District of Michigan, the Defendants,

RICHARD M. ROSENBAUM,  
EDWARD SCOTT CUNNINGHAM, and  
CHRISTINA A. FLOCKEN,

aided and abetted by one another and by persons known and unknown to the Grand Jury, and for the purpose of commercial advantage and private financial gain, did conceal, harbor, and shield from detection more than 100 aliens, knowing or in reckless disregard of the fact that the aliens had come to, entered, or remained in the United States in violation of law.

8 U.S.C. § 1324(a)(1)(A)(iii)  
8 U.S.C. § 1324(a)(1)(A)(v)(II)  
8 U.S.C. § 1324(a)(1)(B)(i)

**COUNTS 3-22**

(Willful Failure To Collect, Account for, and Pay Employment Taxes)

On or about the dates set forth below, in Grand Traverse County in the Southern Division of the Western District of Michigan, and elsewhere, the Defendants,

RICHARD M. ROSENBAUM,  
EDWARD SCOTT CUNNINGHAM, and  
CHRISTINA A. FLOCKEN,

who, as persons conducting a business under the name Rosenbaum-Cunningham International, Inc., with its principal place of business in West Palm Beach, Florida, were required under Title 26, United States Code, to collect, account for, and pay over taxes imposed by Title 26, United States Code, including but not limited to Federal income tax withholding and Federal Insurance Contributions Act (FICA) taxes from the total taxable wages of employees of Rosenbaum-Cunningham International, Inc., did willfully fail to collect, truthfully account for, and pay over to the Internal Revenue Service, and cause not to be collected, truthfully accounted for, and paid over to the Internal Revenue Service, the Federal income tax withholding and FICA taxes that were due and owing to the United States of America in the sums set forth below for the tax periods (quarters) set forth below for the wages set forth below:

Count	Date	Tax period (Quarter) ending	Approximate wages	Approximate taxes
3	April 30, 2001	March 31, 2001	\$57,287.00	\$24,805.00
4	July 31, 2001	June 30, 2001	58,188.00	25,195.00
5	October 31, 2001	September 30, 2001	16,266.00	6,962.00
6	January 31, 2002	December 31, 2001	66,048.00	28,269.00
7	April 30, 2002	March 31, 2002	76,415.00	32,324.00

8	July 31, 2002	June 30, 2002	103,324.00	43,706.00
9	October 31, 2002	September 30, 2002	117,638.00	49,761.00
10	January 31, 2003	December 31, 2002	94,335.00	39,904.00
11	April 30, 2003	March 31, 2003	132,721.00	53,487.00
12	July 31, 2003	June 30, 2003	120,974.00	48,753.00
13	October 31, 2003	September 30, 2003	148,002.00	59,645.00
14	January 31, 2004	December 31, 2003	139,874.00	56,369.00
15	April 30, 2004	March 31, 2004	159,821.00	64,408.00
16	July 31, 2004	June 30, 2004	214,786.00	86,559.00
17	October 31, 2004	September 30, 2004	238,177.00	95,985.00
18	January 31, 2005	December 31, 2004	197,135.00	79,445.00
19	April 30, 2005	March 31, 2005	208,218.00	83,911.00
20	July 31, 2005	June 30, 2005	265,295.00	106,914.00
21	October 31, 2005	September 30, 2005	211,220.00	85,122.00
22	January 31, 2006	December 31, 2005	55,371.00	22,314.00
		Totals:	\$2,681,095.00	\$1,093,838.00

26 U.S.C. § 7202

18 U.S.C. § 2

**COUNT 23**  
**(Forfeiture)**

Upon conviction of one or more of the offenses alleged in Counts 1-2 of this Indictment,  
the Defendants,

RICHARD M. ROSENBAUM,  
EDWARD SCOTT CUNNINGHAM, and  
CHRISTINA A. FLOCKEN,

shall forfeit to the United States pursuant to 18 U.S.C. § 982(a)(6)(A)(ii), any property constituting, or derived from, or traceable to, proceeds obtained, directly or indirectly from the violations of 18 U.S.C. § 371 and 8 U.S.C. § 1324(a)(1)(A)(iii), including but not limited to the following:

1. **MONEY JUDGMENT**: A sum of money equal to \$54,000,000 in United States currency representing the amount of proceeds obtained as a result of the violations of Counts 1-2, for which the Defendants are jointly and severally liable.
2. **BANK ACCOUNTS**:
  - a. Bank of America Account No. 005045166263, in the amount of \$372,075.20, registered in the name of Sunchaser Service Corporation, with Richard Rosenbaum being the registered signatory;
  - b. Bank of America Account No. 005491119932, in the amount of \$25,103.37, registered in the name of Monker, LLC, with Richard Rosenbaum and Christine Flocken being the registered signatories;
  - c. Bank of America Account No. 3430687980, in the amount of \$13,380.41, registered in the name of Christina Flocken;

- d. Bank of America Account No. 3734458158, in the amount of \$132,859.94, registered in the name of Christina Flocken;
- e. Bank of America Account No. 003660771899, in the amount of \$233,150.87, registered in the name of RCI, with Richard Rosenbaum and Scott Cunningham being the registered signatories;
- f. Bank of America Account No. 003660771909, in the amount of \$191,053.94, registered in the name of RCI, with Richard Rosenbaum and Scott Cunningham being the registered signatories;
- g. Wachovia Bank Account No. 1020001219141, in the amount of \$19,081.81, registered in the names of Edward Scott Cunningham and Maria Cunningham;
- h. Wachovia Bank Account No. 2000027213221, in the amount of \$13,776.26 as of 2/13/07, registered in the name of RCI Services, Inc; and
- i. Wachovia Bank Account No. 2000027213234, in the amount of \$18,821.98 as of 2/13/07, registered in the name of RCI Services, Inc.

3. REAL PROPERTY:

- a. All that lot or parcel of land, together with its buildings, appurtenances, improvements, fixtures, attachments and easements located at 6106 Wildcat Run, West Palm Beach, Florida, Palm Beach County, titled in the names of Edward Scott Cunningham and his wife, Maria Christina Cunningham, more particularly described as follows:

Lot 50 of Ibis Golf and Country Club Plat No. 7, according to the

Plat thereof, as recorded in Plat Book 67, at Page 152, of the Public Records of Palm Beach County, Florida. Subject to any and all conditions, restriction, limitations and easements of record.  
Assessor's Parcel No. 74-41-42-24-06-000-0500.

- b. All that lot or parcel of land, together with its buildings, appurtenances, improvements, fixtures, attachments and easements located at 325 Cindy Court, Longwood, Florida, Seminole County, titled in the names of Richard M. Rosenbaum and his wife, Marcy H. Rosenbaum, particularly described as follows:

Lot 14, Forest Park Estates, Section Two, according to the Plat thereof as recorded in Plat Book 23, at Pages 64 and 65, Public Records of Seminole County, Florida.  
Subject to any and all conditions, restriction, limitations and easements of record.  
Assessor's Parcel No. 07-21-29-5FD-0000-0140.

- c. All that lot or parcel of land, together with its buildings, appurtenances, improvements, fixtures, attachments and easements located at 429 Vista Oak Drive, Longwood, Florida, Seminole County, titled in the name of Christina A. Flocken, particularly described as follows:

Lot 13, Wingfield North II, according to the Plat thereof as recorded in Plat Book 38, Pages 44, 45, and 46, Public Records of Seminole County, Florida.  
Subject to any and all conditions, restriction, limitations and easements of record.  
Parcel No. 23-20-29-5JZ-0000-0130.

- d. All that lot or parcel of land, together with its buildings, appurtenances, improvements, fixtures, attachments and easements located at 17531 Via Loma Drive, Poway, California, San Diego County, titled in the names of Christina A.

Flocken and Monker LLC, particularly described as follows:

Lot 75 of City of Poway Tract No. 81-01 Unit No. 1 in the City of Poway, County of San Diego, State of California, according to Map thereof No. 11037, filed in the Office of the County Recorder of San Diego County, September 14, 1984.

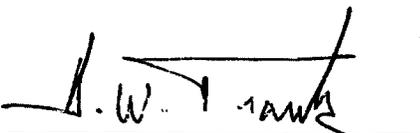
4. SUBSTITUTE ASSETS - If any of the above-described forfeitable property, as a result of any act or omission of the Defendants,
- A. cannot be located upon the exercise of due diligence;
  - B. has been transferred or sold to, or deposited with, a third party;
  - C. has been placed beyond the jurisdiction of the court;
  - D. has been substantially diminished in value; or
  - E. has been commingled with other property which cannot be divided without difficulty,

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p), to seek forfeiture of any other

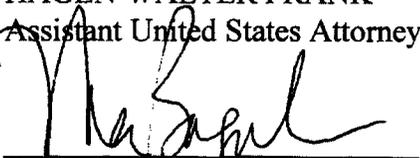
property of the Defendants up to the value of the forfeitable property described above, as being subject to forfeiture.

- 18 U.S.C. § 982(a)(6)(A)(ii)
- 18 U.S.C. § 982(a)(6)(B)
- 18 U.S.C. § 982(b)(1)
- 18 U.S.C. § 371
- 8 U.S.C. § 1324(a)(1)(A)(iii)
- 8 U.S.C. § 1324(b)
- 21 U.S.C. § 853(p)
- 28 U.S.C. § 2461

MARGARET M. CHIARA  
United States Attorney



HAGEN WALTER FRANK  
Assistant United States Attorney



MATTHEW G. BORGULA  
Assistant United States Attorney

A TRUE BILL



GRAND JURY FOREPERSON



**2007**  
**South Carolina**  
**Professional Employer Organization**  
**Continuing Professional Education**  
**Seminar**

**Monday, September 27, 2007**

LEGISLATIVE UPDATE

GARRY SMITH

**Garry Smith, Director**  
Compliance Division  
SC Workers' Compensation Commission

Garry Smith was a draftee during the Vietnam War. He was a first-year high school teacher in Orange Grove, Texas, when he received a military induction notice at the end of the school year. He entered the US Army and underwent Vietnamese language and intelligence training, prior to being assigned to the Republic of Vietnam. Upon his return from Vietnam he was appointed as military intelligence warrant office and continued to serve on active duty. He underwent additional language training to include Arabic and Spanish. His duties consisted primarily of information gathering from interviews. During the early 1980s, he interviewed Cuban refugees that entered the US as a result of the Mariel boatlift. In the late 80s he was assigned to the US Embassy in Bangkok, Thailand. Garry's job was to investigate MIA cases from the Vietnam War. During this period he made eight trips back to Vietnam to conduct on-site MIA investigations. Also he interviewed hundreds of Vietnamese refugees in camps in Hong Kong, Macau, the Philippines, and throughout Thailand. Garry concluded his military service shortly after Operation Desert Storm, during which time he served as an intelligence officer in Saudi Arabia and Kuwait.

After retirement from the US Army, Garry made his home in Columbia, South Carolina, where he began a career in South Carolina state government. His jobs included working as a claims adjuster and investigator for the State Accident Fund and the SC Uninsured Employers' Fund. Since 1998, he has served as the compliance director at the SC Workers' Compensation Commission.

Garry and his wife Betty, an 8<sup>th</sup>-grade science teacher at E.L. Wright Middle School in Columbia, have three married children and five grandchildren. Garry's hobbies include fossil hunting, visiting Civil War battlefields, and touring historical homes with Betty. Garry and Betty are members of Crossings Community Church in Columbia.

# Legislative Update



**Garry Smith, Director  
Compliance Division/SCWCC**



## **South Carolina Workers' Compensation Commission**

# **Insurance and Medical Services Department: regulatory arm of Commission**

- 1) Self-Insurance Division: WC Smith
- 2) Medical Services Division: Julie Lewis
- 3) Coverage Division: Tammie Brasfield
- 4) Compliance Division: Garry Smith



## **South Carolina Workers' Compensation Commission**

### **Coverage Division:**

- 1) NCCI:  
Commercial carriers  
[www.wcc.sc.gov](http://www.wcc.sc.gov)**
  
- 2) Commission:  
State Accident Fund;  
Self-insured employers/funds  
803-737-5708**



## **South Carolina Workers' Compensation Commission**

### **Compliance Division:**

**Conducts investigations to find coverage for claims;**

**Enforces compliance with SC Workers' Compensation Act**



## **South Carolina Workers' Compensation Commission**

**S. 332:**

**Signed by Governor 6/25/07**



## **South Carolina Workers' Compensation Commission**

### **Second Injury Fund:**

**Last date to be eligible: 6/30/2008**

**Notice to SIF: 12/31/2010**

**Final documentation to SIF: 6/30/2011**

**Final acceptance: 12/31/2011**

**SIF terminates: 7/1/2013**



## South Carolina Workers' Compensation Commission

### Commission Forms

Parties must be specific when completing forms:

**X** “all body parts”

**X** “all defenses apply”

Commissioner may consider a condition not included on the original form if it is shown that:

- condition is caused by the injury and the employee did not know about the condition when the form was completed
- the employer had no knowledge of the facts supporting the omitted defense



## South Carolina Workers' Compensation Commission

### **Appeals / Records / Awards**

Appeals: Claims with DOI on or after 7/1/2007 are appealed to the Court of Appeals

Commission will keep files for 15 years beginning with DOI 7/1/07

Commissioners must make written finding substantiating awards



## South Carolina Workers' Compensation Commission

### **Motor Carriers / Independent Contractors**

Exempt from workers' compensation unless the parties mutually agree otherwise.

Lease purchase or installment purchase agreement can be between:

- individual and motor carriers affiliate
- individual and subsidiary or related entity

Lease purchase or installment purchase agreement cannot be between the motor carrier and the individual.



## South Carolina Workers' Compensation Commission

### Awards

Shoulder added to scheduled injuries: 300 weeks

Hip added to scheduled injuries: 280 weeks

Preexisting conditions: employee must have medical evidence to show that the injury aggravated a permanent physical impairment

49% or less loss of use to the back= up to 300 weeks

50% or more loss of use to the back = up to 500 weeks

- proportion to disability, permanent and total presumption is rebuttable



## South Carolina Workers' Compensation Commission

### **Settlement Agreements/Clinchers**

Represented Claimant: employer must file a copy of the agreement with the Commission

Unrepresented Claimant: agreement must be approved by a commissioner



## South Carolina Workers' Compensation Commission

### Occupational Disease

Disease must arise directly and naturally from exposure in SC to hazards peculiar to employment by a preponderance of evidence

Medical Evidence: expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records or other material that is offered by a licensed health care provider

Compensation allowed under total, partial or scheduled injury



## **Repetitive Trauma**

Injury that is gradual in onset and caused by the cumulative effects of repetitive traumatic events

- Commissioner must make a specific finding of fact
- Preponderance of evidence of a causal connection
- Established by medical evidence
- Direct causal relationship between the condition under which the work is performed and the injury

Change of condition must be filed within 1 year after last compensation payment



## **Stress, Mental Illness, Mental Injury**

Burden of Proof:

- Conditions were extraordinary and unusual
- Medical evidence
- Reasonable degree of medical certainty

“Alleged aggravation by a work-related physical injury”

- Admitted by the employer/carrier; or
- An authorized treating physician determines the condition to be causally related to the injury



## **Medical Treatment**

Employer is not responsible for future medicals if there is a lapse in treatment of more than 1 year unless:

- Order/Agreement says otherwise
- Employer attempted to obtain treatment but could not (no fault of his own)

Form 16:

If form does not state that the employer must provide further medical treatment, employer is not responsible for medicals after 1 year



## **South Carolina Workers' Compensation Commission**

### **Release of Medical Records**

Employee is considered to give consent for release of medical records related to his/her injury upon seeking treatment under workers' compensation.

Employee must be given notice of communication between the health care provider and interested parties

Employee must be provided with a copy of written questions at the same time the questions are submitted to the health care provider

Information obtained in violation must be excluded from any proceedings under the provisions of the Act.



## South Carolina Workers' Compensation Commission

### Fines and Contempt

Fines for failure to provide insurance increased to \$1 per day, not to exceed \$100 per day

Failing to abide by an award could result in :

- Paying employee attorney fees
- Fine up to \$500 per day of violation
- Dept. of Insurance may revoke the insurer's license if upon determination failure to pay occurred intentionally 3 times with 2 years



## South Carolina Workers' Compensation Commission

### Fraud

False statement or misrepresentation:

- Intentional acts of false reporting or business activity
- Miscount or misclassification by an employer
- Failure to timely reduce reserves
- Failure to account for SIF or other third party reimbursements
- Failure to provide verifiable information to insurance rating bureaus or the Dept. of Insurance



**South Carolina Workers' Compensation Commission**

# **Ghost policies**



**South Carolina Workers' Compensation Commission**

**Claimant fraud**

**Premium fraud**