TO ALL MEMBER INSURERS:

On behalf of the Association’s Board of Directors, we are pleased to furnish you with several items of information regarding FLAHIGA. The members of the Board are identified along with their terms. Because the Board functions through several committees, the membership of each committee is presented. Following the Board information there is a report of FLAHIGA’s financial activity in 2012 regarding each impaired or insolvent company, along with a breakout of the 2012 assessment. The laws governing the Association are set forth in the Florida Statutes at Chapter 631, Part III. For your convenience, this statutory material is reproduced in this report. Besides the statutes, the Board operates under a Plan of Operation. This Plan is also presented.

Finally, this report concludes with the audited Financial Statement of the Association for the years ended December 31, 2012 and December 31, 2011, as prepared by James D. A. Holley & Co., Certified Public Accountants, Tallahassee, Florida.

Sincerely yours,

Michael A. Jennings
FLAHIGA Chairman
The Prudential Insurance Company of America
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<tr>
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<tr>
<th>REPRESENTATIVES</th>
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<tr>
<td>Eugene Choate</td>
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BOARD OF DIRECTOR TERMS

THREE YEAR TERM EXPIRES AT END OF 2012:

Lincoln National Life Insurance Company
Reliastar Life Insurance Company
Bankers Fidelity Life Insurance Company

THREE YEAR TERM EXPIRES AT END OF 2013:

American Heritage Life Insurance Company
American General Life & Accident Insurance Co.
Metropolitan Life Insurance Company

THREE YEAR TERM EXPIRES AT END OF 2014:

Blue Cross Blue Shield of Florida, Inc.
Liberty National Life Insurance Company
The Prudential Insurance Company of America
NOMINATING COMMITTEE:

Sharon Roberson, Esq., Chair, American General Life & Accident Insurance Company
Russell H. Furtick, Esq., American Heritage Life Insurance Company
John H. Livingston, Esq., Liberty National Life Insurance Company

EXECUTIVE COMMITTEE:

Michael A. Jennings, Esq., Chair, The Prudential Insurance Company of America*
Eugene Choate, Bankers Fidelity Life Insurance Company
Russell H. Furtick, Esq., American Heritage Life Insurance Company
John H. Livingston, Esq., Liberty National Life Insurance Company

AUDIT COMMITTEE:

Henry Grimes, Chair
Martin C. Eltrich, Jr.
David A. Skup, Patriot National Insurance Group

LEGISLATIVE COMMITTEE:

Sharon Roberson, Esq., Chair, American General Life & Accident Insurance Company
Beth P. Lindsay, Reliastar Life Insurance Company
James C. Modaff, BlueCross BlueShield of Florida
Luis Torres, Esq., Metropolitan Life Insurance Company

INVESTMENT COMMITTEE:

Russell H. Furtick, Esq., Chair, American Heritage Life Insurance Company
Eugene Choate, Bankers Fidelity Life Insurance Company
Douglas N. Miller, Lincoln National Life Insurance Company
James C. Modaff, BlueCross BlueShield of Florida

* Also serves as member of all committees through position of Association Chair
2012 FLAHIGA ACTIVITY BY COMPANY IN REHABILITATION OR LIQUIDATION

AMERICAN CHAMBERS LIFE INSURANCE COMPANY

Multi-state Ohio domicile primarily writing health insurance; liquidated 5/8/2000. FLAHIGA general expenses were $802, investment income was $9.

AMERICAN FINANCIAL LIFE INSURANCE COMPANY

Florida domicile writing credit life and credit accident and health, whole life and major medical coverage; liquidated 10/3/1991. FLAHIGA paid $33,320 in claims; general expenses were $3,026; premium collections totaled $21,264; Assessments received during 2012 were $111,440.

AMERICAN INDEPENDENCE LIFE INSURANCE COMPANY

Multi-state Missouri domicile writing life and annuity coverage; liquidated 4/20/1990. FLAHIGA paid $1,723 in claims; general expenses were $1,981; investment income was $7,593.

AMERICAN LIFE ASSURANCE CORPORATION

An Alabama domicile writing annuities, life, accident and health insurance policies; liquidated 5/30/1997; assumed by New Era Life Insurance Company. FLAHIGA general expenses were $50.

AMERICAN STANDARD LIFE & ACCIDENT INSURANCE COMPANY

An Oklahoma domicile company writing annuity, life and health coverage; liquidated 9/22/1998; acquired by American Fidelity Assurance Company. FLAHIGA general expenses were $846; investment income was $91.

AMERICAN SUN LIFE INSURANCE COMPANY

Multi-state Florida domicile primarily writing long-term nursing care and individual medical policies; liquidated 10/18/1989. FLAHIGA paid $18,941 in claims; general expenses were $1,783; premium collections totaled $11,608; investment income was $1,247.

ASSOCIATED LIFE/UNITED FIRE INSURANCE COMPANY

Multi-state Illinois domicile writing ordinary group life insurance and individual and group accident and health insurance policies; liquidated 3/3/1989. FLAHIGA paid $4,663 in claims; general expenses were $1,468; premium collections totaled $156; investment income was $339.

AVAHEALTH INSURANCE COMPANY

AvAHealth, a Florida corporation licensed in 2005, was headquartered in Tampa, Florida. The company was authorized to transact business in the state of Florida as a domestic insurer. AvAHealth wrote health insurance in Florida; liquidated 8/31/2012. FLAHIGA paid $1,014,999 in claims; general expenses were $375,160; premium collections totaled $1,183,247.
BANKERS COMMERCIAL LIFE INSURANCE COMPANY

Multi-state Texas domicile writing life, accident and health coverage; liquidated 6/19/2000. FLAHIGA investment income was $1.

CENTENNIAL LIFE INSURANCE COMPANY

A Kansas domicile company primarily writing major medical and long term disability policies; liquidated 5/27/1998. FLAHIGA paid $587 in claims; general expenses were $83; premium collections totaled $749; distributions in liquidation were $74,337.

CENTRAL LIFE INSURANCE COMPANY OF FLORIDA

Florida domicile primarily writing industrial life insurance; liquidated 8/27/1991. FLAHIGA paid $8,010 in claims; general expenses were $2,925; investment income was $4,507.

CORPORATE LIFE INSURANCE COMPANY

Multi-state Pennsylvania company writing life, annuity and long-term care coverage in Florida; liquidated 2/15/1994; assumed by Metropolitan Life Insurance Company. FLAHIGA paid $3,221 in claims; general expenses were $1,414; premium collections totaled $4,356; investment income was $1,053.

EMPLOYERS LIFE INSURANCE CORPORATION

A South Carolina domicile company writing health policies; liquidated 7/29/2005. FLAHIGA general expenses were $190.

EXECUTIVE LIFE INSURANCE COMPANY

Multi-state California domicile writing life and annuity coverage; liquidated 12/6/1991 and came under FLAHIGA coverage 60 days later on 2/6/1992; assumed by Aurora. FLAHIGA paid $3,458,082 in claims; general expenses were $151,322; investment income was $63,381.

FIRST NATIONAL LIFE INSURANCE COMPANY

An Alabama domicile primarily writing accident and health insurance; liquidated 8/5/1997; American Pioneer assumed all policies. FLAHIGA general expenses were $707; investment income was $2,711.

FIRST NATIONAL LIFE INSURANCE COMPANY OF AMERICA

A Thunor Trust Company, Mississippi domicile writing life and annuity coverage; liquidated 6/29/1999; Madison National assumed this business. FLAHIGA general expenses were $5,468.
FLAHIGA MISCELLANEOUS

Several very small insolvency accounts that are composed primarily of non-cancelable health and life policies have been combined in a single "catch-all" category, and balances remaining in closed estates are moved to this account by line of business. FLAHIGA general expenses totaled $46,954; premium collections totaled $28; investment income was $101,679; distributions from the estate for Consumers United were $8,200; and distributions from the estate for Lincoln Memorial were $5,497; and distributions from the estate for Ideal Mutual were $1,107. Total distributions for FLAHIGA Miscellaneous were $14,804.

FRANKLIN AMERICAN LIFE INSURANCE COMPANY

A Thunor Trust Company, Tennessee domiciled primarily writing life and annuity coverage; liquidated 10/26/1999; assumed by Investors Heritage Life. FLAHIGA general expenses were $268; investment income was $391.

FRANKLIN PROTECTIVE LIFE INSURANCE COMPANY

A Thunor Trust Company, Mississippi domicile writing life and annuity coverage; liquidation 6/29/1999; Madison National assumed this business. FLAHIGA general expenses were $90.

IMERICA LIFE AND HEALTH INSURANCE COMPANY

An Arkansas domicile primarily writing high-deductible health insurance; liquidated 05/03/2010. FLAHIGA paid $1,942 in general expenses; distributions in liquidation were $337.

INTERNATIONAL FINANCIAL SERVICES LIFE

A Thunor Trust Company, Missouri domicile writing deferred annuity business that was acquired by assumption reinsurance agreement; liquidated 6/29/1999; Madison National assumed remaining business. FLAHIGA general expenses were $47; investment income was $1.

KENTUCKY CENTRAL LIFE INSURANCE COMPANY

A Kentucky domicile company writing all types of life and annuity coverage; liquidated 8/18/1994; assumed by Jefferson-Pilot Life Insurance Company. FLAHIGA general expenses were $3,224; investment income was $11,426.

LATIN AMERICAN LIFE INSURANCE COMPANY

Florida domicile writing life and health coverage; liquidated 5/8/1989. FLAHIGA premium collections totaled $660; general expenses were $23.

LEGION INSURANCE COMPANY

A Pennsylvania domicile Property & Casualty company with health related policies; placed in liquidation 7/28/2003. FLAHIGA general expenses were $1,406; distributions in liquidation were $588.
LIFE AND HEALTH INSURANCE COMPANY OF AMERICA

A Pennsylvania domicile writing all types of business; liquidated 7/2/2004. FLAHIGA paid $1,058,265 in claims; general expenses were $87,100; premium collections were $179,702; Assessments received during 2012 were $167,160.

LONDON PACIFIC LIFE AND ANNUITY COMPANY

A North Carolina domicile writing all types of business; liquidated 9/30/2004. FLAHIGA general expenses were $327; investment income was $9.

LUMBERMAN'S LIFE INSURANCE COMPANY

Multi-state Indiana domicile primarily writing Multiple Employer Health Trust coverage; liquidated 11/9/1988. FLAHIGA paid $1,253 in claims; general expenses were $4,532; premium collections totaled $561; investment income was $6,374.

MEDICAL SAVINGS INSURANCE COMPANY

Multi-state Indiana domicile writing primarily high-deductible health insurance policies; placed in liquidation 2/27/2009. FLAHIGA paid $2,343,161 in claims; general expenses were $502,395; Assessments received in 2012 were $2,135,939.

MONARCH LIFE INSURANCE COMPANY

Multi-state Massachusetts domicile; placed in rehabilitation 6/9/1994. FLAHIGA general expenses were $150.

NATIONAL AMERICAN LIFE INSURANCE COMPANY

Pennsylvania domicile company primarily writing accident and health coverage; liquidated 5/31/1996; assumed by Acacia National Life Insurance Company. FLAHIGA general expenses were $3,608; investment income was $12,389.

NATIONAL HERITAGE LIFE INSURANCE COMPANY

A Delaware domicile; liquidated 11/21/1995; Single Premium Ordinary Life policies assumed by Madison National Life Insurance Company, life and annuities assumed by Metropolitan Life. FLAHIGA general expenses were $33,312; investment income was $53,839.

NATIONAL STATES INSURANCE COMPANY

A Missouri domicile primarily writing life, accident and health, long-term care and Medicare Supplement policies; liquidated 11/15/2010. FLAHIGA paid $7,634,924 in claims; general expenses were $1,002,738; premium collections were $3,867,460; Assessments received in 2012 were $1,671,604.

OLD COLONY LIFE INSURANCE COMPANY

A Georgia domicile company writing life and annuity coverage; liquidated 6/30/1994; assumed by AETNA. FLAHIGA general expenses were $764; investment income was $2,363.
PENN TREATY

A Pennsylvania domicile placed in rehabilitation 1/06/2009. FLAHIGA general expenses were $396,404.

RELIANCE INSURANCE COMPANY

A Pennsylvania domicile Property and Casualty company with health related policies; liquidated 10/3/2001. FLAHIGA paid $29,555 in claims; general expenses were $4,466; investment income was $4.

SHENANDOAH LIFE INSURANCE COMPANY

A Virginia domicile placed in rehabilitation on 2/12/2009 and released from oversight 5/8/2012. FLAHIGA general expenses were $15,728.

STANDARD LIFE INSURANCE COMPANY OF INDIANA

An Indiana domicile liquidated 7/26/2012. FLAHIGA paid $8 in claims; general expenses were $19,491.

STATES GENERAL LIFE INSURANCE COMPANY

A Texas domicile company primarily writing health coverage; liquidated 3/9/2005. FLAHIGA general expenses were $289.

SUMMIT NATIONAL LIFE INSURANCE COMPANY

Multi-state Pennsylvania domicile writing life and annuity coverage; liquidated 11/1/1994; assumed by Midland National. FLAHIGA general expenses were $3,864; investment income was $15,158.

F.S. SECTION 631.717(6)

FLAHIGA obligations were fulfilled with $1,040 in general expenses.
2012 FLAHIGA ASSESSMENT

Class A Assessment

“A” Assessment Per Member - $250.00

Class B Assessment

No Assessment
PART III
LIFE AND HEALTH INSURANCE
GUARANTY OF PAYMENTS

631.711 Short title.
631.712 Purpose; construction.
631.713 Application of part.
631.714 Definitions.
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631.718 Assessments.
631.72 Premium or income tax credits for assessments paid.
631.721 Plan of operation.
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631.727 Immunity.
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631.733 Stay of proceedings.
631.734 Reopening default judgments.
631.735 Prohibited advertisement of Florida Life and Health Insurance Guaranty Association Act in sale of insurance.
631.737 Rescission and review generally.
631.711 Short title.—This part may be cited as the "Florida Life and Health Insurance Guaranty Association Act."
631.712 Purpose; construction.—The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against the failure of an insurer issuing such policies or contracts to perform its contractual obligations due to its impairment or insolvency; and this part shall be liberally construed to carry out its purpose.
631.713 Application of part.—
(1) This part shall apply to direct life insurance policies, health insurance policies, annuity contracts, and supplemental contracts with or without life contingencies issued by persons licensed to transact such insurance in this state.
(2) Coverage under this part shall be provided to:
(a) Persons who, regardless of where they reside, except for nonresident certificateholders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under paragraph (b); and
(b) Persons who are owners of or certificateholders under such policies or contracts, and who:
1. Are residents of this state; or
2. Are residents of other states, but only if:
   a. The insurers which issued such policies or contracts are domiciled in this state;
   b. Such insurers were not licensed in the states in which such persons reside at the time specified in a state’s guaranty association law as necessary for coverage by that state’s association;
   c. Such other states have associations similar to the association created by this part; and
   d. Such persons are not eligible for coverage by such associations.
(3) This part does not apply to:
(a) That portion or part of a variable life insurance contract or variable annuity contract not guaranteed by an insurer.
(b) That portion or part of any policy or contract under which the risk is borne by the policyholder.
(c) Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.
(d) Fraternal benefit societies as defined in s. 632.801.
(e) Health maintenance insurance.
(f) Dental service plan insurance.
(g) Pharmaceutical service plan insurance.
(h) Optometric service plan insurance.
(i) Ambulance service association insurance.
(j) Preneed funeral merchandise or service contract insurance.
(k) Prepaid health clinic insurance.
(l) Any annuity contract or group annuity contract that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed directly and not through an intermediary to an individual by an insurer under such contract or certificate. This paragraph applies to every insolvency regardless of its date of inception, and an assessment base may not include premiums for such excluded products.
(m) Any federal employees’ group policy or contract that, under 5 U.S.C. s. 8909(f), is prohibited from being subject to an assessment under s. 631.718.
(n) A portion of a policy or contract, to the extent that the rate of interest on which the policy or contract is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:
1. Averaged over the period of 4 years immediately preceding the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting 2 percentage points from Moody’s Corporate Bond Yield Average averaged for that same 4-year period or for such lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier; and
2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from the most current version of Moody’s Corporate Bond Yield Average.
(o) A portion of a policy or contract to the extent the policy or contract provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which has not been credited to the policy or contract, or as to which the policy or contract owner’s rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this part. However, if the interest or change in value is credited less frequently than annually as determined by using the procedures defined in the policy or contract, interest or change in value shall be credited by using the procedure defined in the policy or contract as if the contractual date of crediting interest or changing values
was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture.
(p) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Medicare Part C or Part D or any regulations issued pursuant to Medicare Part C or Part D.
(4) This part shall only apply to those delinquency proceedings occurring on or after October 1, 1979.
(5) Notwithstanding any other provisions of this part, this part applies to coverage of a person who is a payee under a structured settlement annuity, or a beneficiary if the payee is deceased, with a coverage limit of $300,000 by the association, if:
(a) The payee is a resident of this state, regardless of where the contract owner resides.
(b) Neither the payee, the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the contract owner resides.
(6) “Impaired insurer” means a member insurer deemed by the department to be potentially unable to fulfill its contractual obligations and not an insolvent insurer.
(7) “Insolvent insurer” means a member insurer authorized to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction.
(8) “Member insurer” means any person licensed to transact in this state any kind of insurance as set out in s. 631.713.
(9) “Premium” means any direct gross insurance premium and any annuity consideration written on covered policies, less return premium and consideration thereon and dividends paid or credited to policyholders on such direct business. “Premium” does not include any additional amounts so borrowed are restored to the appropriate accounts not less than annually.
(3) The association shall come under the immediate supervision of the department and shall be subject to the applicable provisions of the insurance laws of this state.
(b) Borrowing between accounts for payment of policyholder and contract holder claims and other obligations of the association is authorized at the discretion of the board of directors, provided that the amounts so borrowed are restored to the appropriate accounts not less than annually.
(3) The association shall come under the immediate supervision of the department and shall be subject to the applicable provisions of the insurance laws of this state.
(4) “Contractual obligation” means any obligation under covered policies.
(5) “Covered policy” means any policy or contract set out in s. 631.713 and reduced to written, printed, or other tangible form.
(6) “Shall” means any direct gross insurance premium and any annuity consideration written on covered policies, less return premium and consideration thereon and dividends paid or credited to policyholders on such direct business. “Premium” does not include any additional amounts so borrowed are restored to the appropriate accounts not less than annually.
(7) “Member insurer” means any person licensed to transact in this state any kind of insurance as set out in s. 631.713.
(8) “Premium” means any direct gross insurance premium and any annuity consideration written on covered policies, less return premium and consideration thereon and dividends paid or credited to policyholders on such direct business. “Premium” does not include any additional amounts so borrowed are restored to the appropriate accounts not less than annually.
(9) “Person” means any individual, corporation, partnership, association, or voluntary organization.
(10) “Resident” means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed by such impaired or insolvent member insurer. A person may be a resident of only one state, which in the case of a person other than an individual shall be the person’s principal place of business. Citizens of the United States who are residents of foreign countries or United States possessions, territories, or protectorates that do not have an association similar to the guaranty association created by this part shall be deemed residents of the state of domicile of the insurer issuing the policies or contracts.
(2)(a) For purposes of administration and assessment, the association shall maintain three accounts:
1. The health insurance account;
2. The life insurance account; and
3. The annuity account.
(1) There is created a nonprofit legal entity to be known as the Florida Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state, and, further, as a condition of such authority, an insurer shall agree to reimburse the association for all claim payments the association makes on said insurer’s behalf if such insurer is subsequently rehabilitated. The association shall perform its functions under the plan of operation established and approved under the provisions of s. 631.721 and shall exercise its powers through a board of directors established under the provisions of s. 631.716.
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department shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

History.—s. 6, ch. 79-189; s. 409(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.717 Powers and duties of the association.

(1) If a domestic insurer is an impaired insurer, the association may, subject to the approval of the impaired insurer and the department:

(a) Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurer;

(b) Provide such moneys, pledges, notes, guarantees, or other means that are proper to effectuate paragraph (a) and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a); and

(c) Loan money to the impaired insurer.

(2) If a domestic insurer is an insolvent insurer, the association shall, subject to the approval of the department:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of persons referred to in s. 631.713(2); and

(b) Provide moneys, pledges, notes, guarantees, or other means that are proper and reasonably necessary to implement paragraph (a) in order to assure payment of the contractual obligations of the insolvent insurer with regard to persons referred to in s. 631.713(2).

(3) If a foreign or alien insurer is an insolvent insurer, the association shall, subject to the approval of the department:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of residents of this state; and

(b) Provide moneys, pledges, notes, guarantees, or other means that are proper and reasonably necessary to implement paragraph (a) in order to assure payment of the contractual obligations of the insolvent insurer with regard to persons referred to in s. 631.713(2).

However, this subsection does not apply when the department has determined that the foreign or alien insurer’s domiciliary jurisdiction or state of entry provides, by statute, protection substantially similar to that provided by this part for residents of this state.

(4)(a) In carrying out its duties under the provisions of subsections (2) and (3), the association may impose a lien on the premiums of any permanent policy or contract in connection with any guarantee, assumption, or reinsurance agreement made by it. Such lien may be enforced by a court of competent jurisdiction if the court:

1. Finds that the amounts which may be assessed under this part are less than the amounts needed to assure full and prompt performance of the insolvent insurer’s contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, to be in the public interest; and

2. Approves the specific policy liens or contract liens to be used.

(b) Before becoming obligated under the provisions of subsections (2) and (3), the association may request that temporary moratoria or liens be imposed on payments of cash values and policy loans in addition to any contractual provisions for deferral of cash or policy loan values. Such temporary moratoria and liens may be imposed if they are approved by a court of competent jurisdiction.

(5) If the association fails to act within a reasonable period of time as provided in subsections (2) and (3), the department shall have the powers and duties of the association under this part with respect to insolvent insurers.

(6) The association may assist and advise the department, upon its request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer. The association may also assist and advise departments of insurance of other states; other guaranty associations; and conservators, rehabilitators, and receivers appointed or acting in regard to any member insured wherever located, for the purpose of developing plans to coordinate protection of policyholders. Costs of such activities may be charged against the health insurance account, the life insurance account, or the annuity account created by s. 631.715, at the discretion of the board of directors, notwithstanding any other provision of this part.

(7) The association shall have standing to appear before any court in this state which has jurisdiction over an impaired or insolvent insurer to which the association is or may become obligated under this part. Such standing shall extend to all matters germane to the powers and duties of the association, including but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations.

(8)(a) Any person receiving benefits under this part shall be deemed to have assigned her or his rights under the covered policy to the association to the extent of the benefits received, whether the benefits are payments of contractual obligations or continuations of coverages. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this part upon such person. The association shall have subrogation rights against the assets of any insolvent insurer.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the insolvent insurer as those possessed by the person entitled to receive benefits under this part.

(9) The association’s liability for the contractual obligations of the insolvent insurer shall be as great as, but no greater than, the contractual obligations of the insurer in the absence of such insolvency, unless such obligations are reduced as permitted by subsection (4), but the aggregate liability of the association shall not exceed $100,000 in net cash surrender and net cash
withdrawal values for life insurance, $250,000 in net
cash surrender and net cash withdrawal values for
defered annuity contracts, or $300,000 for all benefits
including cash values, with respect to any one life. In no
event shall the association be liable for any penalties or
interest.
(10) The association may:
(a) Enter into such contracts as are necessary or
proper to carry out the provisions and purposes of this
part.
(b) Sue or be sued, including the taking of any legal
actions necessary or proper for the recovery of any
unpaid assessments under s. 631.718, provided that
service of process shall be made upon the person
registered with the department as agent for receipt of
service of process.
(c) Borrow money to effect the purposes of this part.
Any notes or other evidence of indebtedness of the
association not in default shall be legal investments for
domestic insurers and may be carried as admitted
assets.
(d) Employ or retain such persons as are necessary
to handle the financial transactions of the association
and to perform such other functions as become
necessary or proper under this part.
(e) Negotiate and contract with any liquidator, reha-
bilitator, conservator, or ancillary receiver to carry out
the powers and duties of the association.
(f) Take such legal action as may be necessary to
avoid payment of improper claims.
(g) Exercise, for the purposes of this part and to the
extent approved by the department, the powers of a
domestic life or health insurer, but in no case may the
association issue insurance policies or annuity con-
tracts other than those issued to satisfy the contractual
obligations of the impaired or insolvent insurer.
(11) The association shall not be liable for any civil
action under s. 624.155 arising from any acts alleged to
have been committed by a member insurer prior to its
liquidation. This subsection does not affect the associ-
ation’s obligation to pay valid insurance policy or
contract claims if warranted after its independent de
novo review of the policies, contracts, and claims
presented to it, whether domestic or foreign, after a
Florida domestic rehabilitation or a liquidation.
(12)(a) The association, when dealing only with life
and health insurance policies under subsections (2) and
(3), may make substitute coverage on an individual or
group basis available to each known insured, or owner if
other than the insured, or to an individual who is insured
under a group policy as of the date the association
became obligated and who is not eligible for replace-
ment group coverage. When providing the substitute
coverage, the association may offer either to reissue the
terminated policy or to issue an alternative policy
without requiring evidence of insurability or any waiting
period or exclusion that would not have applied under
the terminated policy.
(b) The association may reissue any alternative or
reissued policy under this subsection.
(c) Alternative or reissued policies adopted by the
association are subject to the approval of the depart-
ment upon terms and conditions the department
considers appropriate, given the function and special
purpose of the association. The association may adopt
alternative policies of various types for future issuance
without regard to any particular impairment or insolu-
ency.
(d) Alternative or reissued policies must contain at
least the minimum statutory provisions required under
this code and provide benefits that are reasonable with
respect to the premium charged. The association shall
set the premium in accordance with a table of rates
adopted by the association. The premium must reflect
the amount of insurance to be provided and the age and
class of risk of each insured, but may not reflect any
changes in the health of the insured occurring since the
original policy was last underwritten.
(e) Alternative policies issued by the association
must provide coverage of a type generally similar to
that of the policy issued by the impaired or insolvent
insurer, as determined by the association.
(f) The association’s obligations with respect to
coverage under any policy of the impaired or insolvent
insurer or under any reissued or alternative policy must
cease on the date that the coverage is replaced by
another similar policy by the association. Any reissued,
reinsured, or alternative policy must, however, be
subject to association coverage if the replacement
insurer becomes impaired or insolvent as otherwise
provided for in this part.
(g) In carrying out its duties in connection with
guaranteeing, assuming, or reinsuring policies or con-
tracts under subsections (2) and (3), the association
may, subject to approval of the receivership court, issue
substitute coverage for a policy or contract that provides
an interest rate, crediting rate, or similar factor deter-
mind by use of an index or other external reference
stated in the policy or contract employed in calculating
returns or changes in value by issuing an alternative
policy or contract. In lieu of the index or other external
reference provided for in the original policy or contract,
the alternative policy or contract must provide for a fixed
interest rate, payment of dividends with minimum
guarantees, or a different method for calculating interest
or changes in value. In such case:
1. There is no requirement for evidence of insur-
ability, waiting period, or other exclusion that would not
have applied under the replaced policy or contract.
2. The alternative policy or contract shall be sub-
stantially similar to the replaced policy or contract in all
other material terms.
History.—s. 7, ch. 79-185; s. 809(1st), ch. 82-243; s. 10, ch. 85-339; ss. 99, 187,
188, ch. 91-108; s. 4, ch. 91-429; s. 12, ch. 92-328; s. 4, ch. 95-213; s. 414, ch.
97-102; s. 7, ch. 2010-49; s. 12, ch. 2011-226.

631.718 Assessments.—
(1) For the purpose of providing the funds necessary
to carry out the powers and duties of the association,
the board of directors shall assess the member insurers
separately, for each of the accounts referred to in s.
631.715 at such time and for such amounts as the board
finds necessary. Assessments shall be due not less
than 30 days after written notice to the member insurers.
(2) There shall be two classes of assessments, as
follows:
(a) Class A assessments shall be made by the board of directors for the purpose of meeting administrative costs and other general expenses and for examinations conducted under the authority of s. 631.723(3) which are not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be made by the board of directors for the purpose of carrying out the powers and duties of the association under s. 631.717 relating to an impaired or insolvent domestic, foreign, or alien insurer.

(3) (a) The amount of any Class A assessment shall be determined by the board and may be made on a non-pro rata basis. The assessment may not be credited against future insolvency assessments and may not exceed $250 per member insurer in any one calendar year.

(b) The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer.

(c) Class B assessments against member insurers for each account must be based upon the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the 3 most recent calendar years for which information is available preceding the year of the assessment in proportion to premiums received on business in this state for those calendar years by all assessed member insurers. If the most recent 3 years of premium information is not available for each member insurer, the board of directors may use the premium information that is reasonably available.

(d) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be made until necessary to implement the purposes of this part.

(e) Classification of assessments under subsection (2) and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(5) (a) The total of all assessments upon a member insurer for each account may not exceed 1 percent of the sum of the insurer’s premiums written in that state regarding business covered by the account received during the 3 calendar years preceding the year in which the assessment is made, divided by three. If premium information for the 3-year period is not reasonably available for each member insurer, the association may use any reasonably available premium information.

(b) The provisions of this subsection apply to any assessments made on or after October 1, 1995, without regard to the date of the impairment or insolvency.

(c) If the maximum assessment, together with the other assets of the association in its nonadministrative accounts, does not provide in any one year in any account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this part.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to an account, the amount by which the assets of such account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(8) The association shall issue to each insurer paying an assessment under this part, other than a Class A assessment, a certificate of contribution, in a form prescribed by the department, for the amount of the assessment so paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the department approves. However, any amount offset pursuant to s. 631.72 may not be shown as an asset of the insurer on any of its financial statements.

(9) Notwithstanding any provision to the contrary, no member insurer that is a nonprofit insurance company which issues annuity contracts or group annuity contracts pursuant to s. 121.35, or for the benefit of employees of educational institutions situated in this state may be assessed in any one calendar year an amount greater than the amount which it paid to this state in the previous year as premium tax and corporate income tax liabilities imposed under s. 220.11 or its corporate income tax liabilities imposed under s. 220.11 any assessment described in s. 631.718(8) as follows:

(a) For each assessment levied before January 1, 1997, 0.1 percent of the amount of such assessment, less any refunds received pursuant to s. 631.718(6), for

631.72 Premium or income tax credits for assessments paid.—

(1) A member insurer may offset against either its premium tax liabilities imposed under s. 624.509 or its corporate income tax liabilities imposed under s. 220.11 any assessment described in s. 631.718(8) as follows:

(a) For each assessment levied before January 1, 1997, 0.1 percent of the amount of such assessment, less any refunds received pursuant to s. 631.718(6), for
each year following the year in which such assessment was paid until such time as the total of all offsets claimed for a given year’s assessment, whether pursuant to this section or pursuant to prior law, equals the amount of the assessment originally paid in that year.

(b) For each assessment levied and paid after December 31, 1996, 5 percent of the amount of the assessment, less any refunds received pursuant to s. 631.718(6), for each of the 20 calendar years following the year in which the assessment was paid.

(c) An insurer may not offset both its premium tax and corporate income tax liabilities for the same assessment amount. An insurer may only offset its tax liability for one tax to the extent that the offset has not already been used to offset its tax liability for the other tax.

(d) The first tax return on which a member insurer may claim a credit provided in this section is the tax return filed in 1998, covering tax year 1997.

(2) If a member insurer ceases doing business in this state and surrenders to the office its certificate of authority to transact insurance in this state, all uncredited assessments may be credited as provided in this section against either its premium or corporate income tax liabilities imposed pursuant to s. 624.508 and 220.11 for the year it ceases doing business.

(3) Any sums acquired by refund pursuant to s. 631.718(6) from the association which have theretofore been written off by contributing insurers and offset against premium or corporate income taxes as provided in subsection (1) and which are not needed for purposes of this part shall be paid by the insurer to the Department of Revenue for deposit with the Chief Financial Officer to the credit of the General Revenue Fund.

631.721 Plan of operation.—

(a) The association shall submit to the department a proposed plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The proposed plan of operation and any amendments thereto shall become effective upon approval in writing by the department.

(b) If the association fails to submit a suitable proposed plan of operation within 180 days following October 1, 1979, or if at any time thereafter the association fails to submit suitable amendments to the plan, the department shall, after notice and hearing, adopt such reasonable rules as are necessary to effectuate the provisions of this part. Such rules shall continue in force until modified by the department or superseded by a proposed plan submitted by the association and approved by the department.

(2) All member insurers shall comply with the approved plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(a) Establish procedures for handling the assets of the association.

(b) Establish the amount and method of reimbursing members of the board of directors under s. 631.716.

(c) Establish regular places and times for meetings of the board of directors.

(d) Establish procedures for keeping records of all financial transactions of the association, its agents, and the board of directors.

(e) Establish procedures whereby selections for the board of directors shall be made and submitted to the department.

(f) Establish any additional procedures for assessments under s. 631.718.

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under ss. 631.717(10)(c) and 631.718, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the department and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this part.
of the action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of the appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the office shall be subject to judicial review in a court of competent jurisdiction.

(5) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this part.

History.—s. 11, ch. 79-189; s. 809(1st), ch. 82-243; ss. 100, 187, 188, ch. 91-108; s. 4, ch. 91-429; s. 1361, ch. 2003-261.

631.723 Prevention of insolvencies.—To aid in the detection and prevention of insurer insolvencies or impairments:

(1) The board of directors may, upon majority vote, make reports and recommendations to the department or office upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations are confidential and exempt from the provisions of s. 119.07(1) until the termination of a delinquency proceeding.

(2) It is the duty of the board of directors, upon a majority vote, to notify the office of any information indicating that any member insurer may be an impaired or insolvent insurer.

(3) The board of directors may, upon majority vote, request that the office order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within 30 days of the receipt of such a request, the office shall begin such an examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the office designates. The cost of such examination shall be paid by the association, and the examination report shall be treated in a manner similar to other examination reports pursuant to s. 624.319. In no event may such examination report be released to the board of directors before its release to the public, but this does not preclude the office from complying with s. 631.398(2). The office shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the office; such request is confidential and exempt from the provisions of s. 119.07(1) until the examination report is released to the public.

(4) The board of directors may, upon majority vote, make recommendations to the office for the detection and prevention of insurer insolvencies.

History.—s. 12, ch. 79-189; s. 809(1st), ch. 82-243; s. 36, ch. 83-38; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429; s. 4, ch. 93-118; s. 387, ch. 96-406; s. 1362, ch. 2003-261.

631.724 Records and meetings of association.

Records shall be kept of all negotiations and meetings in which the association or its representatives discuss the activities of the association in carrying out its powers and duties under s. 631.717. Such negotiations or meetings are exempt from the provisions of s. 286.011, and any records of such negotiations or meetings are confidential and exempt from the provisions of s. 119.07(1) until the termination of a delinquency proceeding. Nothing in this section shall limit the duty of the association to render a report of its activities under s. 631.725.

History.—s. 13, ch. 79-189; s. 435, ch. 81-259; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429; s. 5, ch. 93-118; s. 388, ch. 96-406.

631.725 Examination of the association; annual report.—The association shall be subject to examination and regulation by the department. The board of directors shall submit to the department, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the department and a report of its activities during the preceding calendar year.

History.—s. 14, ch. 79-189; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.726 Tax exemptions.—The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

History.—s. 15, ch. 79-189; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.727 Immunity.—There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, the Chief Financial Officer, or the department or office or their representatives for any action taken by them in the performance of their powers and duties under this part. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

History.—s. 16, ch. 79-189; s. 809(1st), ch. 82-243; ss. 101, 187, 188, ch. 91-108; s. 4, ch. 91-429; s. 1363, ch. 2003-261.

631.728 Extent of liability of association.—For the purpose of carrying out its obligations under this part, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to s. 631.717(8). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. An asset attributable to covered policies, as used in this section, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

History.—s. 13, ch. 79-189; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.729 Liability of insureds for unpaid assessments.—No provision of this part shall be construed to reduce the liability for unpaid assessments of the
631.7295 Reinsurance.—With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent such contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making such election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date on which the order of liquidation or rehabilitation was entered.

History.—s. 8, ch. 2010-49.

631.731 Liquidation, rehabilitation, or conservation proceedings; distributions.—
(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under s. 631.717 with respect to such insurer has been fully recovered by the association.

History.—s. 13, ch. 79-189; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.733 Stay of proceedings.—All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties.

History.—s. 17, ch. 79-189; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.734 Reopening default judgments.—As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

History.—s. 18, ch. 79-189; s. 809(1st), ch. 82-243; ss. 187, 188, ch. 91-108; s. 4, ch. 91-429.

631.735 Prohibited advertisement of Florida Life and Health Insurance Guaranty Association Act in sale of insurance.—A person may not make, publish, disseminate, circulate, or place before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Florida Life and Health Insurance Guaranty Association Act. However, this section does not apply to the Florida Life and Health Insurance Guaranty Association or any other entity that does not sell or solicit insurance. This section also does not prohibit the furnishing of written information that is in a form prepared by the association, that summarizes the claim, cash value, and annuity cash value limits of the association, upon request of the policyholder or applicant for insurance.

History.—s. 9, ch. 2010-49.
Article 1. Plan of Operation

This Plan of Operation, hereinafter referred to as the Plan, shall become effective upon written approval of the Department of Insurance as provided in Section 631.721(1)(a), Florida Statutes, of the Florida Life and Health Insurance Guaranty Association Act, Chapter 631, Part III, Florida Statutes.

Article 2. Board of Directors

A. There shall be a Board of Directors in accordance with the provisions of Section 631.716, Florida Statutes.

1. The initial Board of Directors shall consist of nine (9) member insurers who shall serve for a term of one (1) year. Thereafter, the Board of Directors shall consist of nine (9) member insurers to be elected for terms of three (3) years so that the terms of all Directors shall not expire in the same year. To provide for staggered terms, some Directors elected initially for terms of less than three (3) years. The Board of Directors shall be elected by the member insurers as provided in Section 631.716, Florida Statutes, and shall fairly represent member insurers. In the event the Department shall determine that all member insurers are not fairly represented, it shall disapprove the membership of the Board and order another election. In the interim between such disapproval and the subsequent election, the Department may appoint a temporary Board of Directors which fairly represents the member insurers. Each member of the Board shall designate its representative and any alternate from the same member insurer.

2. Upon the election of the Board of Directors, the Association shall notify the Department and request its written approval of the Board as elected.

3. The members elected to the Board of Directors shall,

a. Elect a Chair, Vice Chair, Secretary, and Treasurer from among its members, and such other officers as it deems necessary. The posts of Secretary and
Treasurer may be held by the same member.

b. The Chair shall appoint from among its members, a nominating committee. Such committee shall select a nominee to succeed each board member whose term expires at the annual meeting of the Board. Such nominee shall be made known to the member insurers at least 90 days prior to the annual meeting. Other nominees may be submitted to the Board, but not less than 60 days prior to the annual meeting, upon the petition of ten (10) member insurers.

c. In the event there is more than one nominee for each position to be filled, the Board shall make the names of said nominees known to member insurers at least 30 days prior to the annual meeting of the Board, and the election of new Board members shall be by mail ballot of all member insurers in accordance with Section B. In the event there is not more than one nominee for each position to be filled, the Secretary shall cast one ballot for each such nominee.

d. The previously elected Board members shall serve until their successors have been duly elected and qualified to serve.

4. Vacancies occurring on the Board of Directors between annual meetings of the Board shall be filled by a majority vote of the remaining members of the Board with the approval of the Department. Vacancies occurring in elective offices between annual meetings shall be filled by majority vote of the Board. Such appointees shall serve for the unexpired term.

B. The initial Board of Directors shall be elected by the member insurers at the organizational meeting, with each insurer being entitled to one vote in person or by proxy. At subsequent annual meetings of the Board, Directors shall be elected by member insurers by votes cast on a weighted basis using the net Florida direct premiums received as provided by the Department for the last available year for the kinds of insurance specified in Section 631.713, Florida Statutes. Each member insurer shall have at least one vote in electing a member to the Board of Directors. In the event there are more nominations than positions to be filled, the member insurers receiving the greatest number of votes, on a non-cumulative basis, shall be elected.

C. At any meeting of the Board of Directors, each member of the Board shall have one vote. Meeting participation may be through telephonic or physical presence, or by written consent. A majority of the Board (however participating) shall constitute a quorum for the transaction of business and the acts of a majority of the Board members participating at a meeting at which a quorum is deemed present shall be the acts of the Board. Notwithstanding the foregoing, the affirmative vote of a majority of the full Board (however participating) is required to:

1. Approve a contract with a servicing facility;

2. Levy an assessment or provide for a refund;
3. Borrow money, lend money or establish or change a line of credit;

4. Approve reinsurance contracts, assumption agreements or guaranty plans;

5. Adopt amendments to this Plan; and

6. Recommend statutory changes to Chapter 631, Part III.

By such vote, the Directors may also authorize the Chairman, the Executive Committee or other persons to revise as necessary, as well as to execute, all documentation required to give effect to the Board's action.

D. An annual meeting of the Board shall be held at the office of the Association in Jacksonville, Florida, on the second Friday in the month of January, unless the Board, upon proper notice, shall designate some other date or place.

At each annual meeting the Board shall:

1. Review the Plan and submit proposed amendments, if any, to the Department for approval.

2. Review each outstanding contract or agreement, if any, and recommend necessary or desirable corrections, improvements or additions.

3. Review operating expenses and outstanding contractual obligations and determine if an assessment, or a refund of a prior assessment is necessary for the proper administration of the Association and if so, the amount of either. If such assessment or refund is deemed to be necessary, the Board shall levy such assessment or make such refund in accordance with Section 631.718, Florida Statutes and as set forth in Section E. 6. of this Plan. The Board may waive the collection of any assessment from a member insurer in accordance with Section 631.718(4), Florida Statutes.

4. Review, consider and act on any other matters deemed by it to be necessary and proper for the administration of the Association.

E. The Board shall hold other meetings at such times and with such frequency as it deems appropriate to conduct the business of the Association. At meetings called for the purpose of considering matters arising from the impairment or insolvency of a member insurer the Board shall:

1. Consider and determine the legal obligations of the Association with regard to any reported impairment or insolvency.

2. Consider and decide what method, methods or facilities, as permitted under Section 631.717, Florida Statutes, shall be adopted or utilized to assure fulfillment of obligations of the impaired or insolvent member insurer for each of the categories of covered policies. If the Board decides to contract with a servicing facility, every
effort shall be made to secure the participating of liquidators, rehabilitators, conservators, or ancillary receivers, if any, in such contract to assist the Association in the performance of its legally imposed duties.

3. Consider and decide what immediate action, if any, should be taken to assure the proper retention of the records of the impaired or insolvent member insurer which are deemed necessary to the prompt and economical handling by the Association of its legally imposed duties.

4. Consider and decide what persons, if any, should be hired or engaged by the Association to implement and carry out broad directives of the Board made pursuant to its statutorily imposed duties. Such persons may include attorneys at law, actuaries, accountants, claims personnel and such other specialists or persons whose advice or assistance is deemed by the Board to be necessary to the discharge of its duties imposed by law. The Board may agree to compensate such persons so as to best serve the interest of the Association and the public.

5. Consider and decide to what extent and in what manner the Board shall exercise the powers authorized by Section 631.717(10)(f), Florida Statutes, to bring legal actions or provide for the defense thereof in order to avoid payment of improper claims.

6. Consider and decide what assessment, if any, should be levied, whether any refund should be made to a member insurer, and consider and decide whether any assessment shall be deferred or abated. If such assessment, refund, deferral or abatement shall be determined to be appropriate, such action or actions shall be in accordance with the requirements specified in the appropriate item or items of Section 631.718, Florida Statutes.

The Board shall promptly inform the Department of the failure of any member to pay an assessment made pursuant to this paragraph when due. In regard to refunds, the Board shall determine if an excess of funds in any account exists such that the funds could be reasonably considered for refunding. The Board's review for this purpose shall include, but not limited to, a review of assets accruing from assignment, subrogation, net realized gains on estate distributions and income from investments. If the Board determines that such an excess exists, it can in its sole discretion, and in proportion to the contribution of each insurer to that account (to the extent it can be reasonably determined):

a. Refund in cash; or,

b. Refund in the form of a credit against any future assessments with respect to that account; to the extent a credit is granted to an insurer, it shall be reflected in the next subsequent assessment of the insurer for that account; or,

c. Reallocate excess funds to any other impairment or insolvency within the same account, or place the excess funds in a composite account to be held for that purpose.
In order to avoid disproportionate clerical expense, the Board may establish an amount below which refunds shall not be made.

7. Take all steps permitted by law, and deemed necessary, to protect the Association's rights as pertaining to the impaired or insolvent member insurer and its policyholders. In addition to the foregoing powers, the Board shall have and exercise such other powers as may be reasonably necessary to implement its powers and responsibilities under the Act.

8. Issue to each member insurer a certificate of contribution for each Class (b) assessment paid, showing the amount paid by each such insurer, the date of the assessment, name of the particular insolvent or impaired insurer for which the assessment was made, the value of such certificate as determined by the Department, if any, and such other information as the Board shall find relevant.

9. In addition to the foregoing powers, the Board shall have and exercise such other powers as may be reasonably necessary to implement the provisions of the Act.

F. Special meeting of the Board of Directors may be called by the Chairman and shall be called upon request of any two Board members and not less than five (5) days' notice shall be given to each Board member at the time, place and purpose or purposes of any such special meeting. Any Board member not present may consent in writing to any specified action taken by the Board, but this shall not permit Board members to act through other Board members by proxy. Any action approved by the required number of board members at such special meeting, including those consenting in writing, shall be as valid a Board action as though authorized at an annual or a regular meeting of the Board. At such special meeting the Board may consider and decide any matter deemed by it to be necessary for the proper administration of the Association.

G. Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors upon approval of such expenses by the Treasurer or Chairman but members of the Board shall not otherwise be compensated by the Association for their services. In accord with FS 631.716(3), the following expenses are generally recognized as reimbursable to members of the Board of Directors: reasonable travel expenses, meals and lodging directly connected with the attendance at meetings, conferences and seminars in furtherance of the Association's purposes; fees levied by any sponsoring organization for attendance at the organization's events which are directly related to the discharge of duties and obligations of FLAHIGA as a director; books, tapes and electronic materials directly relating to the discharge of duties and obligations as a director of FLAHIGA, such items being recognized as property of FLAHIGA. If any request for reimbursement is questioned by the persons authorized to approve and to pay the requested reimbursement, the matter shall be referred to the Audit Committee for review.

H. Upon receipt of a domestic Rehabilitation or a domestic or foreign Liquidation Order regarding a member insured, the Chairman of the Board of Directors is empowered to call a meeting of the Executive Committee, with notice to all members of the Board of
Directors. The Executive Committee shall be empowered at its discretion to grant funding requests relating to records stabilization and hardship claims, provided however, any funds authorized by the Executive Committee shall be from existing account balances.

**Article 3. Operations**

A. The official address of the Association shall be in the city of Jacksonville, Florida, unless otherwise designated by the Board of Directors.

B. The Board of Directors may employ or engage such persons, firms, or corporations to perform such administrative functions as are necessary for the Board's performance of the duties imposed upon the Association, including attorneys at law, actuaries, accountants, claims personnel and such other specialists or persons whose advice or assistance is deemed by the Board to be necessary to the discharge of its duties. Such persons may include an Executive Director who would render services as may be appropriate for the purpose of the Association as may be announced by the Chair and the Board from time to time. Such a person shall be knowledgeable about insurance matters, conversant with the law as it relates to covered policies of insurance and administratively capable of implementing the directives of the Chair and the Board, while exercising independent judgment. The Board may use the mailing address of such person, firm or corporation as the official address of the Association. Such persons, firms, or corporations shall keep and maintain such records of the activities as may be required by the Board.

C. The Board may open such bank accounts as necessary for the proper administration of association business. The Treasurer shall recommend for the Board's consideration and approval check signature limits, wire authority limits, authorized personnel and procedures regarding all financial accounts. Reasonable delegation of authority regarding such accounts for Association business will be made consistent with prudent fiscal policy. The Treasurer shall also recommend at each Annual Meeting, and from time to time as necessary, an investment policy to be approved by the Board.

D. In order to effectuate the purposes set forth in Section 631.723, Florida Statutes, concerning the prevention of impairments, the Board of Directors may develop procedures for discovering and reporting any member insurer that may be insolvent or in an impaired financial condition which is hazardous to the interest of the policyholders of such insurer or to the public interest. No such reports shall be considered public documents. The Board of Directors may review the Insurance Code and appropriate regulations with a view toward making recommendations to the Department for the improved and more certain detection and prevention of member insurer insolvencies or impairments.

E. The following committees shall be standing committees annually appointed or reappointed by the Chair: Nominating Committee (principal task is to nominate officers and directors); Executive Committee (principal task is to provide administration supervision of FLAHIGA between Board meetings and to otherwise undertake such duties and responsibilities as are agreed to by a majority of the full board); Audit Committee (principal task is to review annual audit process and to review and comment
upon such financial matters as may be referred to it by the Chair, the Treasurer of the Executive Director); Legislative Committee (principal task is to consider proposed amendments and interpretations of the FLAHIGA Act, and to assist with drafting of same and to otherwise render assistance with legislative issues); Investment Committee (principal task is to formulate a sound investment strategy for FLAHIGA while recognizing the special purpose of the association; the Committee assists in the selection of providers of investment services and the monitoring of their performance consistent with the approved investment strategy. All Committees shall report to the directors at least annually as may be requested by the Chair. In addition to appointing the committees, the FLAHIGA Chair shall appoint their respective chairs.

**Article 4. Records and Reports**

A. Minutes of the proceeding of each Board meeting shall be made. The original of these minutes, after approval by the Board, shall be signed by the Chair or the Secretary of the Board of Directors with copies being furnished to each Board member and to the Division of Rehabilitation and Liquidation, Department of Financial Services. The approved original minutes shall be kept on file in the Association's office. Copies of such minutes shall be provided to a member insurer upon request, but information contained herein specifically regarding any member insurer in rehabilitation, impairment, liquidation or administrative supervision, or similar status (regardless of the state of domicile) may be withheld until termination of such status.

B. The Board of Directors shall make any annual report as required by Section 631.725, Florida Statutes, not later than May 1 of each year to the Department. Such report shall include a financial report for the preceding calendar year in a form approved by the Department and a review of the activities of the Association during the preceding calendar year.

C. In the event a member insurer shall be declared an "impaired insurer" or insolvent insurer" as defined in Section 631.714, Florida Statutes, which necessitates the levy of an assessment by the Association or the procurement of funds in a manner authorized to the Association, the Board Chairman shall, once each calendar year, appoint an audit committee. The audit committee shall consist of three persons with insurance accounting or financial service experience, at least two of whom shall not be on the Board of Directors. One or more may be, but none need be, member insurers. Such committee shall see to the proper auditing of all books and records of the Association and shall report its findings to the Board of Directors.

D. Records, reports and all other documents are to be retained for the period of their immediate use, unless longer retention is required for historical reference, contractual or legal requirements, or for other purposes as identified in the Association's Document Retention and Destruction Policy. Materials no longer required, or having satisfied their recommended period of retention, are to be destroyed in an appropriate manner. The Document Retention and Destruction Policy shall be attached to the FLAHIGA Procedures Manual.
E. The Association's work with the National Organization of Life and Health Insurance Company Guaranty Associations ("NOLHGA") and with life and health guaranty associations in other states generates multi-party insolvency-related documents, including those executed by representatives of FLAHIGA. The original executed documents are normally maintained by NOHLGA on behalf of the guaranty association system, with the participant associations affected by an insolvency receiving copies. In such cases, copies of multi-party insolvency related materials shall be maintained by the Associations as though they were original documents.

F. The Association shall maintain, and update from time to time, a Procedures Manual at its offices which shall generally catalogue the various operations of the Association and serve as a resource for the guidance of persons performing services for or on behalf of the Association. The Procedures Manual is deemed a resource to be reasonably interpreted under the prevailing circumstances, and not a mandate for absolute compliance.

**Article 5. Membership**

A. Each insurer which was admitted as of October 1, 1979, to transact the kinds of insurance covered by the Florida Life and Health Insurance Guaranty Association Act in the State of Florida shall be a member insurer of this Association. Each insurer admitted after said date to transact the kinds of insurance covered by said Act shall automatically become, effective on the date of its admission, a member insurer of the Association. A member insurer which ceases to be admitted after said date shall automatically cease to be a member effective on the day following the termination of expiration of its license to transact the kinds of insurance covered by said Act; provided, however, such insurer shall remain liable for any assessment or assessments based on an insolvency or insolvencies occurring prior to the cessation of its status as a member Insurer in the Association.

B. Any member insurer aggrieved by an act of the Association shall appeal to the Board of Directors before appealing to the Department of Financial Services. If such member insurer is aggrieved by the final action or decision of the Board, or if the Board does not act on such complaint within 30 days, the member insurer may appeal to the Department within 30 days after the action or decision of the Board or the expiration of the 30 day period within which the Board failed to act on such complaint. Any member insurer which makes an appeal to the Department of Financial Services pursuant to this Article must provide the Association with notice of the appeal by sending a copy of the Appeal to the Association by certified mail, courier service requiring a signed receipt, or by hand no later than the day following the day on which the appeal was sent to the Department of Financial Services. Failure to notify the Association within the time and in the manner set forth in this Plan shall bar any claim that a member insurer might otherwise have respect to any act taken by the Association or its Board of Directors, unless otherwise agreed to in writing by the Association. Similar requirements for notice of any appeal shall apply to persons or entities other than a member insurer, provided that such person shall first have been notified in writing by the Association of the time limit and the notice requirement.

C. If a member insurer's appeal pertains to a protest of all or part of an assessment, the member insurer shall pay when due the full amount of the assessment as set forth in the
notice of assessment provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or of any subsequent appeal to the judicial system. Payment by a protesting member insurer shall be accompanied by a statement in writing that the payment is made under protest and setting forth a statement of the grounds for the protest.

**Article 6. Indemnification**

A. All persons, except the Department and its representatives, described in Section 631.727, Florida Statutes, shall be indemnified by the Association for all expenses incurred in the defense of any action taken by him in the performance of his powers and duties under the Florida Life and Health Insurance Guaranty Association Act, unless such person shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance or reckless disregard of the responsibilities of his office. In the event of adjudication, such indemnity shall be provided only if the Association is advised by independent counsel that such person did not, in such counsel's opinion, commit such a breach of duty. The expense of such indemnification shall be assessed against member insurers in accordance with Section 631.718, Florida Statutes.

B. This Article is intended to operate as a supplement and additional safeguard to, and not in place of, the immunity granted by Section 631.727, Florida Statutes.

**Article 7. Conformity to Statute**

Chapter 631, Part III, Florida Statutes, as written, and as may be hereafter amended, is incorporated as a part of this Plan.

**Article 8. Code of Ethics / Conflicts of Interest**

No member of the Board of Directors shall participate in any matter which would inure to its special private gain beyond any benefits to be normally anticipated because of being a member insured without first disclosing interest in the matter. The bar to participation shall include participating in Board discussions and voting on the subject. Public disclosure may be written or may be announced verbally with a request that the interest be recorded in the official minutes. Such disclosure shall be made at the earliest opportunity.

Board members, their representatives, employees and all persons engaged in the performance of work or services on behalf of the Association shall abide by the following principles:

1. No favor, gift or other consideration which could reasonably be perceived as tending to influence any decision made or to be made on behalf of the Association, or in discharge of its statutory responsibilities, can be accepted;

2. No non-public information acquired as a result of the performance of Association duties can be used to derive any personal monetary benefit, through securities trading or purchasing or otherwise, directly or indirectly;
3. Non-public and confidential information will be communicated or disseminated only to Board members, employees or persons engaged to assist the Association or other like guaranty associations and those employed or engaged by them relating to statutory duties, to governmental departments and personnel, or to other persons or entities as may be directed by the Association, all on a "need to know" basis and under circumstances where the recipient of such information has committed to keep such information confidential and not use such information outside of the scope of his/her authority;

4. Any interest in any matter which might reasonably represent a conflict of interest or the appearance of a conflict of interest within the context of the interests of the Association, its obligations to policyholders and the full and fair execution of the Association's duties and responsibilities, shall be avoided;

5. No unlawful, improper or unethical conduct shall be participated in on behalf of the Associations or in the course of performing work or services for the Association;

6. No member of the Board of Directors shall participate in any matter which would inure to its special private gain beyond any benefits to be normally anticipated because of being a member insurer without first disclosing interest in the matter, which disclosure shall be recorded in the official records of the Association; and,

7. No member of the Board of Directors shall vote on, or seek to influence the voting on, that member's involvement in any assumption reinsurance, third party administration arrangement, or other financial arrangement to which that member, or any known affiliate, is a party participant.

8. Board members, their representatives, employees and persons engaged by contract by the association with decision making authority shall be required to annually sign a statement that: a) they have received and have read the Code of Ethics/Conflicts of Interest section of the FLAHIGA Plan of Operation; and, b) they have not knowingly violated the requirements and restrictions therein. The executed statements shall be returned to, and kept with the files of the association.

Violations of the above principles shall be treated as serious matters and shall immediately be reported to the Association's General Counsel or to the Chair, or both. The Chair may seek guidance and direction from the General Counsel, and/or the Chair may refer the matter to the Audit Committee for review of the facts and its recommendation to the Board of Directors. Besides measures to remove any conflict of interest and to see that ethical practice is restored or upheld, the Board of Directors may take such action as a majority shall deem appropriate under the circumstances. Particular questions regarding conflict issues may be presented to the General Counsel, Department of Financial Services, on a consultation basis.

All direct engagement letters and contracts for employment with, or for services to, the Association relating to its statutory duties shall reference this Article and shall provide that compliance therewith shall be an express condition of the engagement, employment or contract. A copy of this Article shall be supplied to all engaged, employed or contracting parties providing such services.
Communications regarding inquiries or concerns about any matter addressed in this Article, other than reports of violations, shall be first directed to the Association's General Counsel, who shall keep the Chair and the Board appropriately informed. Compliance with this Article shall be reported upon at every Annual Meeting.

Version: 2011
Approved by DFS June 20, 2011
FLORIDA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION

AUDITED FINANCIAL STATEMENTS

For the years ended December 31, 2012 and 2011
INDEPENDENT AUDITORS' REPORT

Board of Directors
Florida Life and Health Insurance
Guaranty Association
Jacksonville, Florida

Report on the Financial Statements

We have audited the accompanying financial statements of Florida Life and Health Insurance Guaranty Association which comprise the balance sheets as of December 31, 2012 and 2011, and the related statements of changes in fund balances for the years then ended, and the related notes to the financial statements.

Management’s Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor’s Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation in the financial statements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

**Opinion**

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Florida Life and Health Insurance Guaranty Association as of December 31, 2012 and 2011, and the changes in fund balances for the years then ended in accordance with accounting principles generally accepted in the United States of America.

**Report on Supplemental Information**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information contained in page 7 is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

April 26, 2013

[Signature]
## FLORIDA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
### BALANCE SHEETS
December 31, 2012 and 2011

### ADMINISTRATIVE FUND

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<thead>
<tr>
<th>ASSETS</th>
<th>2012</th>
<th>2011</th>
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<td>Assessment receivable</td>
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<td>$ 55,750</td>
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<td>Due from impairment fund</td>
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<tr>
<td>Office equipment</td>
<td>$ 13,306</td>
<td>$ 14,088</td>
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<tr>
<td>Less accumulated depreciation</td>
<td>(11,194)</td>
<td>(11,247)</td>
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<tr>
<td></td>
<td><strong>$ 76,866</strong></td>
<td><strong>$ 60,871</strong></td>
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### LIABILITIES AND FUND BALANCE

| Fund balance                  | **$ 76,866** | **$ 60,871** |
|                               | **$ 76,866** | **$ 60,871** |

### IMPAIRMENT FUND

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<thead>
<tr>
<th>ASSETS</th>
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<th>2011</th>
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<td>Cash</td>
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<td>Assessment receivable</td>
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<tr>
<th>LIABILITIES AND FUND BALANCE</th>
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<tr>
<td>Claims payable</td>
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</tr>
<tr>
<td>Due to administrative fund</td>
<td>$ 69,554</td>
<td>$ 2,280</td>
</tr>
<tr>
<td></td>
<td>$ 74,789,615</td>
<td>$ 78,343,129</td>
</tr>
<tr>
<td>Fund balance</td>
<td>$ 21,850,806</td>
<td>$ 24,421,024</td>
</tr>
<tr>
<td></td>
<td><strong>$ 96,640,421</strong></td>
<td><strong>$ 102,764,153</strong></td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
## FLORIDA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
### STATEMENTS OF CHANGES IN FUND BALANCES
For the years ended December 31, 2012 and 2011

### ADMINISTRATIVE FUND

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning balances</td>
<td>60,871</td>
<td>97,721</td>
</tr>
<tr>
<td>Increases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>157,500</td>
<td>158,250</td>
</tr>
<tr>
<td>Decreases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>52,195</td>
<td>66,247</td>
</tr>
<tr>
<td>Accounting</td>
<td>12,115</td>
<td>14,483</td>
</tr>
<tr>
<td>Consultant</td>
<td>1,000</td>
<td>7,541</td>
</tr>
<tr>
<td>Directors meetings and travel</td>
<td>28,418</td>
<td>37,632</td>
</tr>
<tr>
<td>Office expense</td>
<td>29,427</td>
<td>30,683</td>
</tr>
<tr>
<td>Insurance</td>
<td>6,673</td>
<td>6,347</td>
</tr>
<tr>
<td>Telephone and internet</td>
<td>6,051</td>
<td>8,639</td>
</tr>
<tr>
<td>Payroll taxes and expenses</td>
<td>4,014</td>
<td>3,660</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,612</td>
<td>1,118</td>
</tr>
<tr>
<td>Loan commitment fees</td>
<td></td>
<td>18,750</td>
</tr>
<tr>
<td></td>
<td>141,505</td>
<td>195,100</td>
</tr>
<tr>
<td>Ending balances</td>
<td>76,866</td>
<td>60,871</td>
</tr>
</tbody>
</table>

### IMPAIRMENT FUND

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning balances</td>
<td>24,421,024</td>
<td>21,095,355</td>
</tr>
<tr>
<td>Increases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td>21,365,066</td>
</tr>
<tr>
<td>Premium collections</td>
<td>5,269,791</td>
<td>5,803,717</td>
</tr>
<tr>
<td>Distributions in liquidation</td>
<td>90,067</td>
<td>6,560,622</td>
</tr>
<tr>
<td>Investment income</td>
<td>205,075</td>
<td>292,699</td>
</tr>
<tr>
<td></td>
<td>5,564,933</td>
<td>34,022,104</td>
</tr>
<tr>
<td>Decreases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims paid</td>
<td>15,610,710</td>
<td>22,722,374</td>
</tr>
<tr>
<td>NOLHGA</td>
<td>1,557,031</td>
<td>2,564,285</td>
</tr>
<tr>
<td>Administrative</td>
<td>406,896</td>
<td>133,577</td>
</tr>
<tr>
<td>Legal</td>
<td>426,452</td>
<td>305,620</td>
</tr>
<tr>
<td>Accounting</td>
<td>76,695</td>
<td>50,691</td>
</tr>
<tr>
<td>Consultant fees</td>
<td>3,805</td>
<td>57,404</td>
</tr>
<tr>
<td>Trustee fees</td>
<td>74,409</td>
<td>69,936</td>
</tr>
<tr>
<td>Travel</td>
<td>27,685</td>
<td>11,446</td>
</tr>
<tr>
<td></td>
<td>18,183,683</td>
<td>25,915,333</td>
</tr>
<tr>
<td>Change in estimates:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unbilled assessment increase (decrease)</td>
<td>6,518,532</td>
<td>(20,786,102)</td>
</tr>
<tr>
<td>Claims payable decrease</td>
<td>3,530,000</td>
<td>16,005,000</td>
</tr>
<tr>
<td></td>
<td>10,048,532</td>
<td>(4,781,102)</td>
</tr>
<tr>
<td>Ending balances</td>
<td>21,850,806</td>
<td>24,421,024</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
NOTES TO FINANCIAL STATEMENTS

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Activities
The Florida Life and Health Insurance Guaranty Association is an association of insurers licensed to sell life, annuity, and/or accident and health insurance in the State of Florida. The Association is organized under Chapter 631, Part III, Florida Statutes, for the purpose of protecting policyholders against the failure of an insurer to perform its contractual obligations. The Association is empowered to assess and collect from its members the funds necessary to carry out its purpose.

Accounting Policies
Changes in fund balances are recognized on the accrual basis. A liability for claims assumed is recorded based on the estimated claims payable for each company administered by the Association. An amount for unbilled assessments is recorded, when applicable, to recognize the Association's authority under Chapter 631, Part III, Florida Statutes, to assess its members for all claims and expenses in excess of premiums, recoveries, and interest earned.

The interfund accounts represent the net effect of various financial transactions carried on by each fund on behalf of the other, primarily assessments collected and expenses paid.

Cash
The Association has noninterest-bearing cash deposits at a financial institution which exceed the amount insured by the FDIC.

Property and Equipment
Property and equipment consist of office equipment recorded at cost. Equipment is depreciated using the straight-line method over an estimated useful life of three to four years.

Tax Status
The Association has been determined to be tax exempt as an instrumentality under Section 115 of the Internal Revenue Code.

Use of Estimates
The Association uses estimates and assumptions in preparing financial statements in accordance with generally accepted accounting principles. Those estimates and assumptions affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities, and the reported revenues and expenses. Actual results could vary from the estimates that were assumed in preparing the financial statements.

Date of Management's Review
Subsequent events have been evaluated through April 26, 2013, which is the date the financial statements were available to be issued.
2. INVESTMENTS

Investments are limited to marketable fixed income securities with maturities no greater than two years from the date of purchase. The investments are carried at fair value which is determined by reference to quoted market prices in active markets for identical assets (Level 1 within the fair value hierarchy established by financial accounting standards). The major types of investments are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2012 Market Value</th>
<th>2012 Cost</th>
<th>Unrealized Gain (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money market funds</td>
<td>$1,864,863</td>
<td>$1,863,622</td>
<td>$1,241</td>
</tr>
<tr>
<td>U. S. Treasury securities</td>
<td>20,648,299</td>
<td>20,770,168</td>
<td>$(121,869)</td>
</tr>
<tr>
<td>U. S. Agency securities</td>
<td>28,895,889</td>
<td>28,925,519</td>
<td>$(29,630)</td>
</tr>
<tr>
<td>Corporate bonds</td>
<td>3,092,315</td>
<td>3,183,594</td>
<td>$(90,279)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$54,502,366</strong></td>
<td><strong>$54,742,903</strong></td>
<td><strong>$(240,537)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2011 Market Value</th>
<th>2011 Cost</th>
<th>Unrealized Gain (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money market funds</td>
<td>$19,748,352</td>
<td>$19,748,352</td>
<td>$20,618</td>
</tr>
<tr>
<td>U. S. Treasury securities</td>
<td>10,649,974</td>
<td>10,629,356</td>
<td>$(44,252)</td>
</tr>
<tr>
<td>U. S. Agency securities</td>
<td>17,221,658</td>
<td>17,265,910</td>
<td>$(135,775)</td>
</tr>
<tr>
<td>Corporate bonds</td>
<td>8,644,114</td>
<td>8,779,889</td>
<td>$(159,409)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$56,264,098</strong></td>
<td><strong>$56,423,507</strong></td>
<td><strong>$(159,409)</strong></td>
</tr>
</tbody>
</table>

Investment income includes the following:

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest</td>
<td>$558,245</td>
<td>$649,319</td>
</tr>
<tr>
<td>Net gains (losses)</td>
<td>$(353,170)</td>
<td>$(356,620)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$205,075</strong></td>
<td><strong>$292,699</strong></td>
</tr>
</tbody>
</table>

3. ASSESSMENTS

Class A assessments to cover administrative expenses were $250 per member company in 2012 and 2011. An assessment for Class B of $22,000,000 was made in 2011 for the purpose of fulfilling the Association’s responsibilities as set forth in Section 631.717, Florida Statutes, as they relate to Medical Savings Insurance Company, National States Insurance Company, Life & Health Insurance Company of America, and American Financial Life Insurance Company.

4. REVOLVING CREDIT LINES

The Association had revolving lines of credit totaling ten million dollars which matured in April of 2011. The lines were not drawn on in 2011, but were subject to fees totaling $18,750.
5. CLAIMS PAYABLE

The liability for claims payable is an estimated amount for all impaired companies administered by the Association either directly or indirectly as of December 31 of each year. An annual assessment is made, when necessary, to pay claims estimated to arise from open insolvencies.

Major insolvencies open at December 31, 2012, and their associated estimated claim liabilities are as follows:

<table>
<thead>
<tr>
<th></th>
<th>(x1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Life</td>
<td>$33,200</td>
</tr>
<tr>
<td>National States Insurance Company</td>
<td>30,152</td>
</tr>
<tr>
<td>AvaHealth, Inc.</td>
<td>3,500</td>
</tr>
<tr>
<td>Medical Savings Insurance Company</td>
<td>2,275</td>
</tr>
<tr>
<td>Life &amp; Health Insurance Company of America</td>
<td>1,188</td>
</tr>
<tr>
<td>Lumbermens Life Insurance Company</td>
<td>1,034</td>
</tr>
<tr>
<td>All others</td>
<td>2,900</td>
</tr>
<tr>
<td></td>
<td><strong>74,249</strong></td>
</tr>
<tr>
<td>Less amount funded within one year</td>
<td>19,954</td>
</tr>
<tr>
<td>Amount funded after one year</td>
<td><strong>54,295</strong></td>
</tr>
</tbody>
</table>

6. CONTINGENCIES

Claims in litigation or threatened litigation that result from the Association’s obligation to meet the contractual duties of liquidated insurers are limited by the statutory caps on the Association’s liability on a per life per company basis, and liability is also limited by that section of Chapter 631, Part III, exempting the Association from penalties and interest. Historically, most litigated claims are settled on a compromise basis and, in any event, no claim pending or threatened is greater than an amount on a per life basis case beyond $100,000, $250,000 or $300,000, depending on the applicable statutory cap, as far as can be reasonably anticipated.

The Association has been involved in what began as a class action case with Medical Savings Insurance Company, which is in liquidation. To date, the plaintiffs’ actions have been stayed or dismissed. Their latest motion for rehearing, filed in March of 2013, remains pending. The Association has undertaken a vigorous approach to settlement while following the requirements of the insurance policies. Settlement of all known claims is very close to completion and should be completed by June of 2013. Once these settlements are completed, the class action will largely be moot.

Penn Treaty Network America and its subsidiary have been in rehabilitation since 2009 and have the potential of being placed in liquidation. If liquidation is ultimately ordered, and affirmed if appealed, the Association will have a substantial policyholder obligation likely exceeding $100 million, depending on the circumstances. The nature of the business is long term care policies.

The statutory liability limits on claims and the statutory authority to assess its member insurers to cover claims are designed to cover these potential liabilities. No litigation is anticipated from the Association’s other major insolvencies as listed in the preceding note.
# FLORIDA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Schedule of Changes in Impairment
Fund Balance by Account
For the years ended December 31, 2012 and 2011

<table>
<thead>
<tr>
<th></th>
<th>Life</th>
<th>Annuity</th>
<th>A &amp; H</th>
<th>2012 Total</th>
<th>2011 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beginning balances</strong></td>
<td>$ 15,266,735</td>
<td>$ 9,154,289</td>
<td>$ 0</td>
<td>$ 24,421,024</td>
<td>$ 21,095,355</td>
</tr>
<tr>
<td><strong>Increases:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21,365,066</td>
</tr>
<tr>
<td>Premium collections</td>
<td>303,509</td>
<td>2,052</td>
<td>4,964,230</td>
<td>5,269,791</td>
<td>5,803,717</td>
</tr>
<tr>
<td>Distributions in liquidation</td>
<td>6,590</td>
<td>2,578</td>
<td>80,899</td>
<td>90,067</td>
<td>6,560,622</td>
</tr>
<tr>
<td>Investment income</td>
<td>55,931</td>
<td>132,849</td>
<td>16,295</td>
<td>205,075</td>
<td>292,699</td>
</tr>
<tr>
<td></td>
<td>366,030</td>
<td>137,479</td>
<td>5,061,424</td>
<td>5,564,933</td>
<td>34,022,104</td>
</tr>
<tr>
<td><strong>Decreases:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims paid</td>
<td>221,011</td>
<td>3,459,812</td>
<td>11,929,887</td>
<td>15,610,710</td>
<td>22,722,374</td>
</tr>
<tr>
<td>NOLHGA</td>
<td>124,765</td>
<td>85,950</td>
<td>1,346,316</td>
<td>1,557,031</td>
<td>2,564,285</td>
</tr>
<tr>
<td>Administrative</td>
<td>8,247</td>
<td>8,657</td>
<td>389,992</td>
<td>406,896</td>
<td>133,577</td>
</tr>
<tr>
<td>Legal</td>
<td>29,658</td>
<td>29,135</td>
<td>367,659</td>
<td>426,452</td>
<td>305,620</td>
</tr>
<tr>
<td>Accounting</td>
<td>7,555</td>
<td>7,774</td>
<td>61,366</td>
<td>76,695</td>
<td>50,691</td>
</tr>
<tr>
<td>Consultant fees</td>
<td>3,805</td>
<td>3,805</td>
<td>57,404</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trustee fees</td>
<td>19,669</td>
<td>47,860</td>
<td>6,880</td>
<td>74,409</td>
<td>69,936</td>
</tr>
<tr>
<td>Travel</td>
<td>3,612</td>
<td>3,022</td>
<td>21,051</td>
<td>27,685</td>
<td>11,446</td>
</tr>
<tr>
<td></td>
<td>414,517</td>
<td>3,642,210</td>
<td>14,126,956</td>
<td>18,183,683</td>
<td>25,915,333</td>
</tr>
<tr>
<td><strong>Change in estimates:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unbilled assessment – increase (decrease)</td>
<td>(67,000)</td>
<td>1,050,000</td>
<td>2,547,000</td>
<td>3,530,000</td>
<td>(20,786,102)</td>
</tr>
<tr>
<td>Claims payable – (increase) decrease</td>
<td>(67,000)</td>
<td>1,050,000</td>
<td>9,065,532</td>
<td>10,048,532</td>
<td>(4,781,102)</td>
</tr>
<tr>
<td><strong>Ending balances</strong></td>
<td>$ 15,151,248</td>
<td>$ 6,699,558</td>
<td>$ 0</td>
<td>$ 21,850,806</td>
<td>$ 24,421,024</td>
</tr>
</tbody>
</table>