Adopted: March 5, 1993
Amended: October 2, 1998
Amended: October 6, 2006
Amended: March 6, 2009

# MEMORANDUM OF UNDERSTANDING
# EXCESS LIABILITY PROGRAM

This Memorandum of Understanding is entered into by and between the CSAC Excess Insurance Authority (hereinafter referred to as the "Authority") and the participating members who are signatories to this Memorandum.

1. **JOINT POWERS AGREEMENT.** Except as otherwise provided, all terms used herein shall be as defined in Article 1 of Joint Powers Agreement Creating the Excess Insurance Authority (hereinafter referred to as "Agreement"), provisions of any applicable coverage agreement and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.

2. **ANNUAL PREMIUM.** The participating members, in accordance with the provisions of Article 14(b)(2) of the Agreement, shall be assessed an annual premium for the purpose of funding the Program. Annual premiums shall include the participating member's share of expected losses for the policy period, including incurred but not reported losses (IBNR), as well as margin for contingencies based upon a confidence level as determined by the Board of Directors of the Authority (hereinafter Board), and adjustments, if any, for a surplus or deficit from all program policy periods. In addition, the premium shall include program reinsurance costs and program administrative costs, plus the Authority's general expense allocated to the Program by the Board for the next policy period.

3. **COST ALLOCATION.** Each participating member's share of annual premium shall be determined pursuant to a cost allocation plan as described in Article 14(b)(2) of the Agreement. The Board approved cost allocation plan is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Board representing the members participating in the Program.

4. **DIVIDENDS AND ASSESSMENTS.** The Program shall be funded in accordance with paragraph 2 above. As a general rule, the annual premium, as determined by the Board, shall be established at a level which shall provide adequate overall funding without the need for adjustments to past policy period(s) in the form of dividends and assessments. Should the Program for any reason not be adequately funded, except as otherwise provided herein, pro-rata assessments to the participating members may be utilized to ensure the approved funding level for those policy periods individually or for a block of policy periods, in accordance with the provisions of Article 14(b)(3) of the Agreement. Pro-rata dividends shall be declared as provided herein. Dividends may also be declared as deemed appropriate by the Board.

5. **CLOSURE OF POLICY PERIODS.** Notwithstanding any other provision of this Memorandum, the following provisions are applicable:

(a) Upon reaching ten (10) years of maturity after the end of a program period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those program periods, except as set forth in paragraph 6(a), below;

(b) Notwithstanding subparagraph (a) above, the Board may take action to leave a policy period "open" even though it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Board takes specific action to declare any of the last ten (10) policy periods closed.

(c) Dividends and assessments, other than those set forth in paragraph 6(a) below, shall be administered to the participating members based upon the proportion of premiums paid to the Program in "open" periods only. For purposes of administering dividends and assessments pursuant to this subparagraph, all "open" policy periods shall be considered as one block. New members to the Program shall become eligible for dividends and assessments upon participating in the Program for three consecutive policy periods (not less than 24 months). Participating members who withdraw from the Program prior to the three year policy period restriction are still eligible for any assessments that arose out of the policy years they participated in the Program.

6. **DECLARATION OF DIVIDENDS.** Dividends shall be payable from the Program to a participating member in accordance with its proportionate funding to the Program during all "open" policy periods except as follows:

(a) A dividend shall be declared at the time a program period is closed on all amounts which represent premium surcharge amounts assessed pursuant to Article 14(b)(3) of the Agreement where the funding exceeds the 80% confidence level. This dividend shall be distributed based upon each member's proportionate share of assessment paid and accrued to the policy period being closed.

7. **MEMORANDUM OF COVERAGE.** A Memorandum of Coverage shall be issued by the Authority evidencing membership in the Program and setting forth terms and conditions of coverage.

8. **CLAIMS ADMINISTRATION.** Each participating member shall comply with the Authority's Underwriting and Claims Administration Standards (including Addendum B - Liability Claims Administration Guidelines) as amended from time to time, and which are attached hereto as Exhibit B and incorporated herein.

9. **LATE PAYMENTS.** Notwithstanding any other provision to the contrary regarding late payment of invoices or cancellation from a Program, at the discretion of the Executive

Committee, any member that fails to pay an invoice when due may be given a ten (10) day written notice of cancellation.

10. **RESOLUTIONS OF DISPUTES.** Any question or dispute with respect to the rights and obligations of the parties to this Memorandum regarding coverage shall be determined in accordance with the Joint Powers Agreement Article 31, Dispute Resolution.

11. **AMENDMENT.** This Memorandum may be amended by a two-thirds vote of the Board and signature on the Memorandum by the member's designated representative who shall have authority to execute this Memorandum. Should a member of the Program fail to execute any amendment to this Memorandum within the time provided by the Board, the member shall be deemed to have withdrawn as of the end of the policy period.

12. **COMPLETE AGREEMENT.** Except as otherwise provided herein, this Memorandum constitutes the full and complete agreement of the members.

13. **SEVERABILITY.** Should any provision of this Memorandum be judicially determined to be void or unenforceable such determination shall not affect any remaining provision.

14. **EFFECTIVE DATE.** This Memorandum shall become effective on the effective date of coverage for the member and upon approval by the Board of any amendment, whichever is later.

15. **EXECUTION IN COUNTERPARTS.** This Memorandum may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

In Witness Hereof, the undersigned have executed this Memorandum as of the date set forth below:

Dated: 3/6/2009

_____
CSAC Excess Insurance Authority

Dated: _____

_____
Member Entity: _____

**EXHIBIT A**

# EXCESS LIABILITY PROGRAM
# COST ALLOCATION PLAN

As delegated by the Board of Directors, the Executive Committee will determine the specific allocation of all costs among the members subject to the following parameters:

## Actuarial Analysis

An annual actuarial analysis will be performed using loss and exposure data collected from the members. The analysis will determine the necessary funding rates at various confidence levels and using various discount assumptions. Different rates may be developed for different groups or classes of business as is deemed necessary or appropriate by the Executive Committee. At the March Board meeting, the Board of Directors will select the funding level rates and discount factors to be used based upon the actuarial analysis and recommendations from the actuary, the Underwriting Committee and the Executive Committee.

## Pool Contributions

The total needed pool contribution will be determined by multiplying the rates described above by the exposure for all of the members participating in the pool. For schools, the exposure base will be the reported Average Daily Attendance (ADA). For all other members, the exposure base will be estimated payroll for the year being funded. The Executive Committee may break the pool into different layers for allocation purposes, and may apply a different loss experience modification for each layer as is deemed appropriate based on loss frequency. In general, the lower layers will be subject to greater experience modification and the higher layers will be subject to lower experience modification or no experience modification. Within the layers, the larger members will be subject to greater experience modification than the smaller members. After the experience modification has been applied for each layer, there will be a pro-rata adjustment back to the total needed pool contribution.

## Reinsurance Premiums

The reinsurance premium will be determined through negotiations with the reinsurer(s) and approved by the Board upon recommendation of the Underwriting and Executive Committees. This premium will then be allocated among the members based upon their exposure (ADA or estimated payroll).

## EIA Administration Fees

The total EIA Administration Fees will be determined through the annual budgeting process with an appropriate amount allocated to the Excess Liability Program. These fees will be allocated among the members as determined by the Executive Committee. In general, the basis for this allocation will be each member's percentage of the total pool contributions and reinsurance premium.

## Deviation From the Standard

The Executive Committee may establish policies to deviate from the standard allocation methodology selected for each year on a case-by-case basis, if necessary. They may also elect to further delegate some or all of the decision making herein to the Underwriting Committee.

# Exhibit B

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|---|---|
| Adopted: | December 6, 1985 |
| Amended: | January 23, 1987 |
| Amended: | October 6, 1995 |
| Amended: | October 1, 1999 |
| Amended: | October 3, 2003 |
| Amended: | October 1, 2004 |
| Amended: | March 6, 2009 |

# CSAC EXCESS INSURANCE AUTHORITY
# UNDERWRITING AND CLAIMS ADMINISTRATION STANDARDS

## I. GENERAL

A. Each Member shall appoint an official or employee of the Member to be responsible for the risk management function and to serve as a liaison between the Member and the Authority for all matters relating to risk management.

B. Each Member shall maintain a loss prevention program and shall consider and act upon all recommendations of the Authority concerning the reduction of unsafe conditions.

## II. EXCESS WORKERS' COMPENSATION PROGRAM

A. Members of the Excess Workers' Compensation Program, except those members of the Primary Workers' Compensation Program whose responsibilities are outlined in Section IV below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its workers' compensation claims. At least one person in the claims office (whether in-house or outside administrator) shall be certified by the State of California as a qualified administrator of self-insured workers' compensation plans.

2. Qualified defense counsel experienced in workers' compensation law and practice shall handle litigated claims. Members are encouraged to utilize attorneys who have the designation "Certified Workers' Compensation Specialist, the State Bar of California, Board of Legal Specialization".

3. The Member shall use the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) and shall advise its claims administrator that these guidelines are utilized in the Authority's workers' compensation claims audits.

B. The Member shall provide the Authority written notice of any potential excess workers' compensation claims in accordance with the requirements of the Authority's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of the Authority's Workers'

Compensation Claims Administration Guidelines (Addendum A) or as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) shall be performed once every two (2) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claim experience or number of large claims, or

2. There is a change of workers' compensation claims administration firms, or

3. The Member is a new member of the Excess Workers' Compensation Program.

The claims audit shall be performed by a firm selected by the Authority unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. indemnity, medical, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors, Claims Review Committee, Underwriting Committee, or Executive Committee. Such records shall include both open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

## III. GENERAL LIABILITY PROGRAMS

A. Members of the General Liability I or General Liability II Programs, except those members of the Primary General Liability Program whose responsibilities are outlined in Section V below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its liability claims.

2. Qualified defense counsel experienced in tort liability law shall handle litigated claims. Members are encouraged to utilize defense counsel experienced in the subject at issue in the litigation.

3. The Member shall use the Liability Claims Administration Guidelines (Addendum B) and shall advise its claims administrator that these guidelines are utilized in the Authority's liability claims audits.

B. The Member shall provide the Authority written notice of any potential excess liability claim in accordance with the requirements of the Authority's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of the Authority's Liability Claims Administration Guidelines (Addendum B) or as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claims experience or number of large claims, or

2. There is a change of liability claims administration firms, or

3. The Member is a new member of the General Liability I or General Liability II Program.

The claims audit shall be performed by a firm selected by the Authority unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

## IV. PRIMARY WORKERS' COMPENSATION PROGRAM

A. Members of the Primary Workers' Compensation Program shall provide the third party administrator written notice of any claim in accordance with the requirements of the Authority. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. The Authority shall be responsible for ensuring qualified personnel administer claims in the Primary Workers' Compensation Program and that claims are administered in accordance with the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A).

C. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) is performed once every two (2) years.

D. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

## V. PRIMARY GENERAL LIABILITY PROGRAM

A. Members of the Primary General Liability Program shall provide the third party administrator written notice of any claim or incident in accordance with the requirements of the Authority. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. The Authority shall be responsible for ensuring qualified personnel administer claims in the Primary General Liability Program and that claims are administered in accordance with the Authority's Liability Claims Administration Guidelines (Addendum B).

C. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) is performed once every two (2) years.

D. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

## VI. PROPERTY PROGRAM

A. Members of the Property Program shall maintain appropriate records including a complete list of insured locations and schedule of values pertaining to all real property. Such records shall be provided to the Authority or its brokers as requested by the Executive or Property Committees.

B. Each Member shall perform a real property replacement valuation for all locations over $250,000. Valuations shall be equivalent to the Marshall Swift system and shall be performed at least once every five (5) years. New members shall have an appraisal or valuation performed within one year from entry into the Program.

## VII. MEDICAL MALPRACTICE PROGRAM

A. Program I

1. Members of Medical Malpractice Program I (hereinafter Program I) shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

   a. Members of Program I shall use only qualified personnel to administer its health facility claims.

   b. Qualified defense counsel experienced in health facility law shall handle litigated claims.

   c. Members of Program I shall use the "Claims Reporting and Handling Guidelines" in the CSAC Excess Insurance Authority Medical Malpractice Program Operating and Guidelines Manual (hereinafter Operating and Guidelines Manual), and shall advise its claims administrator that these claims handling guidelines are utilized in the Authority's medical malpractice claims audits.

2. Members of Program I shall provide the Authority written notice of any potential excess claim or "major incident" in accordance with the requirements of the Authority and of the excess carrier as stated in the Operating and Guidelines Manual. Updates on such claims or major incidents shall be provided as requested by the Authority.

3. A claims administration audit utilizing the Authority's Claims Reporting and Handling Guidelines in the Operating and Guidelines Manual shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

   a. There is an unusual fluctuation in the Member's claims experience or number of large claims, or

   b. There is a change of health facility claims administration firms, or

   c. The Member is a new member of the Medical Malpractice Program, or

d. The Medical Malpractice Committee requests an audit. The claims audit shall be performed by a firm(s) selected by the Authority. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

4. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

5. Members of Program I shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

B. Program II

1. For Medical Malpractice Program II (hereinafter Program II) Members, the Authority shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member. The Authority may contract with a third party administrator for handling of such claims.

2. The Authority shall be responsible for ensuring the third party administrator uses qualified personnel to administer Program II claims.

3. The Authority shall be responsible for ensuring qualified defense counsel experienced in health facility law shall handle litigated claims.

4. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Claims Reporting and Handing Guidelines in the Operating and Guidelines Manual shall be performed once every two (2) years.

The claims audit shall be performed by a firm(s) selected by the Authority. Recommendations made in the claims audit shall be

addressed by the third party administrator and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

5. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

## VIII. SANCTIONS

A. The Authority shall provide the Member written notification of the Member's failure to meet any of the above-mentioned standards or of other concerns, which affect or could affect the Authority.

B. The Member shall provide a written response outlining a program for corrective action within sixty (60) days of receipt of the Authority's notification.

C. After approval by the Executive or applicable Program Committee of the Member's corrective program, the Member shall implement the approved program within ninety (90) days. The Member may request an additional sixty (60) days from the Executive or applicable Program Committee. Further requests for extensions shall be referred to the Board of Directors.

D. Failure to comply with subsections B or C may result in cancellation of the Member from the affected Authority Program in accordance with the provisions in the Joint Powers Agreement.

E. Notwithstanding any other provision herein, any Member may be canceled pursuant to the provision of the Joint Powers Agreement.

Adopted: December 6, 1985
Amended: January 23, 1987
Amended: October 6, 1995
Amended: October 1, 1999
Amended: March 2, 2007

# ADDENDUM B
# LIABILITY
# CLAIMS ADMINISTRATION GUIDELINES

The following Guidelines have been adopted by the CSAC Excess Insurance Authority (hereinafter the Authority or the EIA) in accordance with Article 18(b) of the CSAC Excess Insurance Authority Joint Powers Agreement.

## I. CLAIMS INVESTIGATION

A. Factual investigation should be completed within forty-five (45) days of Member's knowledge of claim, including statements from participants and witnesses, appropriate official reports, and photos. (Answer questions who, what, where, when and why).

B. Develop liability issues, including immunities, comparative negligence, joint tort feasors and joint and several liability. Transfer of risk is an important aspect of any claims investigation.

C. Begin to develop information on damages:

1. Property damage
2. Nature and extent of injuries
3. Medical costs
4. Lost wages
5. Dependency
6. Other damages

D. Obtain and review contracts that may be in effect relating to specific accidents, to determine whether there is any sharing or complete transfer of the risk.

1. Hold-harmless indemnity agreements
2. Additional insured requirements.

E. Obtain defective products and/or other evidence, and hold it if at all possible, or at least locate where it is being held. Obtain product information for the file. Early preservation of evidence is imperative for a proper defense.

F. Utilize experts appropriately on cases. Consideration should be given to structured settlements and Voluntary Settlement Conferences. EIA has a resource manual with the names, addresses, etc. on various experts who can be retained to investigate and testify on behalf of the Members.

G. The EIA maintains membership in the Index Bureau.

1. Report all bodily injury claims to the Index Bureau

2. Follow up on Index Bureau information by sending the Inquiry Form to insurance companies reporting other injuries to the claimant. Do not hesitate to call and discuss the losses with other adjusters.

Instruction manuals, reporting forms, inquiry forms and envelopes may be obtained online at Claimsearch.iso.com, after being registered for use by the EIA.

H. Arrange appraisals for damaged property. Do not rely on the appraisal obtained by the plaintiffs' own carriers. In some instances they may not utilize the local A.C.V. and the "computerized" appraisal figure can be inflated.

## II. EXCESS REPORTING REQUIREMENTS

A. First Report

Timely report to the Excess Insurance Authority those losses with potential or existing exposure. Utilize the First Report Potential Excess Liability Claims form currently in use, available through the EIA website.

1. The Excess Liability Programs' reporting criteria are those criterion established and adopted by the Board and/or the Liability II committee.

B. Update Reports

The EIA should be provided copies of periodic reports in order to be kept apprised of the developments of the case. On litigated cases, defense counsel should also include the EIA on their mailing lists for copies of correspondence, reports, evaluations, interrogatory summaries, deposition summaries and medical summaries. Actual deposition transcripts, interrogatories, their answers and interim billings are not required.

On reserving and payment changes utilize the Reserve and Payment Update form currently in use, available through the EIA website.

C. Closure Reports

When a case that has been reported to the EIA is settled, dismissed or closed in any other fashion, provide the EIA with the closing documents and a completed Closure Information form currently in use, available through the EIA website.

## III. TORT CLAIM REQUIREMENTS/GOVERNMENT CODE

A. All notices (pertaining to claim insufficiency, returning late claims, claims rejections, etc.) shall be timely done in accordance with the relevant Governmental Code provisions.

B. Appropriate Dismissal Motions should be made for failure to meet the applicable Code of Civil Procedure statutes for timely serving, conducting discovery or bringing a complaint to trial.

## IV. DOCUMENTATION

A. Accurate reserves shall be established based on facts known, within thirty (30) days of receipt of the investigative report. Legal and adjusting expenses shall be included. The following formula is recommended in establishing and updating the reserves for each file:

1. (Maximum Value x Member's % of Liability) + Expense Factor = Reserve.

   Maximum value is the potential total amount a plaintiff could expect to receive, either through settlement or verdict, as if he/she was completely free of negligence. Maximum value should include any potential award of plaintiff's attorney fees, such as, but not limited to, cases involving Federal Civil Rights.

   Percentage of liability is determined by various factors that are discovered during an investigation. Reserves should be adjusted accordingly, as facts are developed, to properly reflect the exposure. These factors include but are not limited to:

   a. The extent of plaintiff's liability
   b. The number of co-defendants and their percentage of liability
   c. The ability of the co-defendants to respond financially to any settlement or verdict.
   d. On cases occurring after June 3, 1986, Proposition 51 allows defendants to limit their liability on non-economic damages to their percentage of fault.

e. On cases involving uninsured claimants the recovery is limited to economic damages in accordance with California Code of Civil Procedures sections 3333.3 and 3333.4 (Prop 213).

2. The reserve shall be set at the full exposure after applying the above formula, even if it exceeds the Member's Self-Insured Retention.

B. The file shall contain reports necessary to document the decisions made, including all demands, offers of settlement and settlement authority.

1. A complete "typed" captioned report to the file shall be placed in each file for:

a. Bodily Injury claims reserved above 25% of the S.I.R.
b. Property Damage claims reserved above 25% of the S.I.R.
c. All claims that meet the EIA's excess reporting requirements regardless of reserves.

Members and/or claims administrators may follow stricter guidelines.

The captioned report should include the following topical headings and subsequent entries:

1. Date of report
2. Member name
3. S.I.R level
4. Claimant(s) Information
5. Date of Loss
6. Claim Number (if used)
7. Facts of accident or occurrence
8. Witness/Participant Statement
9. Suggested reserves (see IV. A) Do they reflect exposure?
10. Assessment of liability
11. Review of damages/injuries, including medical costs, lost wages, dependency, property damage estimates, total loss evaluations, loss of use claims, and other damages
12. Index Bureau reporting
13. Addressing of coverage questions
14. Excess potential
15. Structured Settlement possibilities
16. Voluntary Settlement Conference potential
17. Subrogation potential
18 Governmental Code compliance and immunities
19. Identify future course of action
20. State next diary date
21. If litigated, identify counsel on both sides.

22. Offsets or liens that may need to be considered.

C. Photos, diagrams, estimates, statements, plans, contracts, medical, law enforcement and coroner's reports (where applicable) shall be in the claims file in a timely fashion.

## V. CASE SETTLEMENT FACTORS

A. The settlement should be reasonable in light of damages, injuries and liability.

B. Settlements should be effected in a timely manner, with consideration given to structures and/or voluntary settlement conferences.

C. Contributions from joint tort feasors should be considered.

D. Settlement evaluation and authority shall be documented. On cases exceeding the S.I.R., prior written authority must be obtained from the EIA.

E. Proper releases and dismissals shall be secured.

## VI. LITIGATED FILES

A. Defense plan shall be in the file, including a projected cost analysis.

B. Defense attorney evaluation shall be completed and in the file within sixty (60) days of assignment.

C. The defense attorney should make proper follow-up requests for investigation.

D. Defense costs shall be controlled by the Member and depositions and other defense expenses approved by the Member.

E. There should be timely recommendations from defense firms regarding settlements and trial preparation.

F. Results and total expenses shall be documented.

G. There should be timely notification to relevant employees and other parties regarding pending litigation.

## VII. SUMMARY

The file should be completely documented. Audits conducted by the EIA Auditor not only utilize industry standards, but also these Guidelines.

The California Unfair Claims Settlement Practices Regulations went into effect on January 15, 1993. These regulations apply to the Insurance Industry as a whole. Public Agencies (including J.P.A.'s) are not governed by these regulations. Many Members utilize outside claims administrators that must comply with these regulations in their private insurance industry work, and have already had their adjusters certified.