HealthMarkets, Inc.
Form 10-K
April 02, 2007

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the Fiscal Year Ended December 31, 2006.

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 [NO FEE REQUIRED]**
For the transition period from to

Commission file no. 001-14953

HealthMarkets, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**75-2044750**
(State or other jurisdiction of Incorporation or organization)	*(IRS Employer Identification No.)*
9151 Boulevard 26	**76180**
North Richland Hills, Texas	*(Zip Code)*
(Address of principal executive offices)	

Registrant s telephone number, including area code:
(817) 255-5200

Securities registered pursuant to Section 12(b) of the Act:
None

Securities registered pursuant to Section 12(g) of the Act:
Class A-2 common stock
(Title of class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No þ

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No þ

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K þ

Indicate by check mark whether the registrant is a large accelerated filer, accelerated filer, or a non-accelerated filer (as defined in Rule 12b-2 of the Act).

Large accelerated filer o Accelerated filer o Non-accelerated filer þ

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No þ

Effective April 5, 2006, all of the registrant s Class A-1 common stock (representing approximately 88.62% of its common equity at March 10, 2007) is owned by three private investor groups and members of management. The registrant s Class A-2 common stock is owned by its independent insurance agents and is subject to transfer restrictions. Neither the Class-A-1 common stock nor the Class A-2 common stock is listed or traded on any exchange or market. Accordingly, as of June 30, 2006, the last business day of the registrant s most recently completed second fiscal quarter, the aggregate market value of shares of Class A-1 and Class A-2 common stock held by non-affiliates was $-0-. As of March 10, 2007, there were 26,892,160.2016 outstanding shares of Class A-1 common stock and 3,454,835.0000 outstanding shares of Class A-2 common stock.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the annual information statement for the annual meeting of stockholders are incorporated by reference into Part III.

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PART I

Item 1. *Business*

Introduction

HealthMarkets, Inc. and its subsidiaries are collectively referred to throughout this Annual Report on Form 10-K as the *Company* or *HealthMarkets* and may also be referred to as *we, us* or *our.*

We offer insurance (primarily health and life) to niche consumer and institutional markets. Through our subsidiaries we issue primarily health insurance policies, covering individuals and families, to the self-employed, association groups and small businesses.

HealthMarkets is a holding company, and we conduct our insurance businesses through our indirect, wholly-owned insurance company subsidiaries, The MEGA Life and Health Insurance Company (MEGA), Mid-West National Life Insurance Company of Tennessee (Mid-West) and The Chesapeake Life Insurance Company (Chesapeake). MEGA is an insurance company domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in all states except New York. Mid-West is an insurance company domiciled in Texas and is licensed to issue health, life and annuity insurance policies in Puerto Rico and all states except Maine, New Hampshire, New York, and Vermont. Chesapeake is an insurance company domiciled in Oklahoma and is licensed to issue health and life insurance policies in all states except New Jersey, New York and Vermont.

Through our Self-Employed Agency Division, we offer a broad range of health insurance products for self-employed individuals and individuals who work for small businesses. Our basic hospital-medical and catastrophic hospital expense plans are designed to accommodate individual needs and include traditional fee-for-service indemnity plans and preferred provider organization (PPO) plans, as well as other supplemental types of coverage. Commencing in 2006, we began to offer on a selective state-by-state basis a new suite of health insurance products to the self-employed and individual market, including a basic medical-surgical expense plan, catastrophic expense PPO plans and catastrophic expense consumer guided health plans.

We market these products to the self-employed and individual markets through independent contractor agents associated with UGA-Association Field Services (the principal marketing division of The MEGA Life and Health Insurance Company) and Cornerstone America (the principal marketing division of Mid-West National Life Insurance Company of Tennessee), which are our dedicated agency sales forces that primarily sell the Company s products. We believe that we have the largest direct selling organization in the health insurance field, with approximately 2,100 independent writing agents per week in the field selling health insurance to the self employed market in 44 states.

Through our Life Insurance Division, we also issue universal life, whole life and term life insurance products to individuals in four markets that we believe are underserved: the self-employed market, the middle income market, the Hispanic market and the senior market. We distribute these products directly to individual customers through our UGA and Cornerstone agents and other independent agents contracted through two key unaffiliated marketing companies. These two marketing companies, in turn, distribute our life products through managing general agent (MGA) networks.

ZON Re USA LLC (an 82.5%-owned subsidiary) underwrites, administers and issues accidental death, accidental death and dismemberment (AD&D), accident medical, and accident disability insurance products, both on a primary and on a reinsurance basis. We distribute these products through professional reinsurance intermediaries and a network of independent commercial insurance agents, brokers and third party administrators (TPAs).

On April 5, 2006, we completed a merger (the Merger) providing for the acquisition of the Company by affiliates of a group of private equity investors, including affiliates of The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners (the Private Equity Investors). *See* Note B of Notes to Consolidated Financial Statements. As a result of the Merger, holders of record on April 5, 2006 of HealthMarkets common shares (other than shares held by certain members of management and shares held through HealthMarkets agent stock accumulation plans) received $37.00 in cash per share. In the transaction, HealthMarkets public

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shareholders received aggregate consideration of approximately $1.6 billion, of which approximately $985.0 million was contributed as equity by the private equity investors. The balance of the Merger consideration was financed with the proceeds of a $500.0 million term loan facility extended by a group of banks, the proceeds of $100.0 million of trust preferred securities issued in a private placement, and Company cash on hand in the amount of approximately $42.8 million.

Our operating segments for financial reporting purposes include (a) the Insurance segment, which includes the businesses of the Company s Self-Employed Agency (SEA) Division, the Life Insurance Division and Other Insurance, (b) Other Key Factors, which includes investment income not otherwise allocated to the Insurance segment, realized gains and losses, interest expense on corporate debt, general expenses relating to corporate operations, variable stock compensation and other unallocated items, and (c) Disposed Operations, which includes the Company s former Star HRG and former Student Insurance Division (which operations were sold on July 11, 2006 and December 1, 2006, respectively). *See* Note T of Notes to Consolidated Financial Statements for financial information regarding our segments.

Our principal executive offices are located at 9151 Boulevard 26, North Richland Hills, Texas 76180-5605, and our telephone number is (817) 255-5200.

As of March 30, 2007, approximately 88% of our common equity securities are held by affiliates of three private equity investors, and as such, we remain subject to the periodic reporting and other requirements of the Securities Exchange Act of 1934, as amended. Our periodic SEC filings, including our annual reports on Form 10-K, quarterly reports on Form 10-Q, Current Reports on Form 8-K, and if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are available through our web site at www.healthmarkets.com free of charge as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC.

Recent Developments Sales of Former Student Insurance Division and Star HRG Division

Our results of operations in 2006 reflected significant gains realized from the sales of our former Star HRG operations and Student Insurance Division, completed on July 11, 2006 and December 1, 2006, respectively. In particular, in 2006 we recognized pre-tax gains in the amount of approximately $101.5 million and $100.2 million in connection with the sale of Star HRG Division and the Student Insurance Division, respectively.

See Management s Discussion and Analysis of Financial Condition and Results of Operations and Note C of Notes to Consolidated Financial Statements for a further discussion of the terms of the sales of the Star HRG Division and the Student Insurance Division.

Ratings

Our principal insurance subsidiaries are rated by A.M. Best, Fitch and Standard & Poor s (S&P). Set forth below are financial strength ratings of the principal insurance subsidiaries.

	A.M. Best	Fitch	S&P
MEGA	A− (Excellent)	A− (Strong)	BBB+ (Good)
Mid-West	A− (Excellent)	A− (Strong)	BBB+ (Good)
Chesapeake	A− (Excellent)	BBB+ (Good)	BBB (Good)

In the table above, the A.M. Best s ratings carry a negative outlook and the Fitch and S&P ratings carry a stable outlook.

In evaluating a company, independent rating agencies review such factors as the company s capital adequacy, profitability, leverage and liquidity, book of business, quality and estimated market value of assets, adequacy of policy liabilities, experience and competency of management, and operating profile. A.M. Best s ratings currently range from A++ (Superior) to F (Liquidation). A.M. Best s ratings are based upon factors relevant to policyholders, agents, insurance brokers and intermediaries and are not directed to the protection of investors. Fitch s ratings provide an overall assessment of an insurance company s financial strength and security, and the ratings are used to support insurance carrier selection and placement decisions. Fitch s ratings range from AAA

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(Exceptionally Strong) to C (Very Weak). S&P s financial strength rating is a current opinion of the financial security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. Standard & Poor s financial strength ratings range from AAA (Extremely Strong) to CC (Extremely Weak).

A.M. Best has assigned to HealthMarkets, Inc. an issuer credit rating of bbb– (Good) with a watch negative outlook. A.M. Best s issuer credit rating is a current opinion of an obligor s ability to meet its senior obligations. A.M. Best s issuer credit ratings range from aaa (Exceptional) to d (In Default).

Fitch has assigned to HealthMarkets, Inc. a long term issuer default rating of BBB (Good) with a stable outlook. Fitch s long term issuer default rating is a current opinion of an obligor s ability to meet all of its most senior financial obligations on a timely basis over the term of the obligation. Fitch s long term issuer default ratings range from AAA (Exceptionally Strong) to D (Default).

Standard & Poor s Rating Services has assigned to HealthMarkets, Inc. a counterparty credit rating of BB+ (Less Vulnerable) with a stable outlook. S&P s counterparty credit rating is a current opinion of an obligor s overall financial capacity to pay its financial obligations. Standard & Poor s counterparty credit ratings range from AAA (Extremely Strong) to D (Default).

Insurance Segment

Self-Employed Agency Division

Through our Self-Employed Agency Division, we offer a broad range of health insurance products for the individual and self-employed market (*i.e.,* self-employed individuals and individuals who work for small businesses) and products for the small (2-15 members) employer group market. The Self-Employed Agency Division generated revenues of $1.462 billion, $1.526 billion and $1.496 billion, representing 68%, 72% and 72% of our total revenue in 2006, 2005 and 2004, respectively. We currently have in force approximately 350,000 health insurance policies issued or coinsured by the Company.

We offer a broad range of health insurance products for self-employed individuals and individuals who work for small businesses:

Our Traditional Health Products

Our traditional health insurance plan offerings for the self-employed market have included the following:

Our Basic Hospital-Medical Expense Plan has a $1.0 million lifetime maximum benefit for all injuries and sicknesses and $500,000 lifetime maximum benefit for each injury or sickness. Covered expenses are subject to a deductible. Covered hospital room and board charges are reimbursed at 100% up to a pre-selected daily maximum. Covered expenses for inpatient hospital miscellaneous charges, same-day surgery facility, surgery, assistant surgeon, anesthesia, second surgical opinion, doctor visits, and ambulance services are reimbursed at 80% to 100% up to a scheduled maximum. This type of health insurance policy is of a scheduled benefit nature, and, as such, provides benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy. These limitations allow for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be lower than future premium increases on our catastrophic policy.

Our Preferred Provider Plan incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. The savings from these negotiated fees reduce the costs to the individual policyholders. The policies that provide for the use of a PPO impose greater policyholder cost sharing if the policyholder uses providers outside of the PPO network.

Our Catastrophic Hospital Expense Plan provides a $2.0 million lifetime maximum for all injuries and sicknesses and a lifetime maximum benefit for each injury or sickness ranging from $500,000 to $1.0 million. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging

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from 50% to 100% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to increase as overall hospital care expenses rise.

Each of our traditional health insurance products is available with a menu of various options (including various deductible levels, coinsurance percentages and limited riders that cover particular events such as outpatient accidents, and doctors visits), enabling the insurance product to be tailored to meet the insurance needs and the budgetary constraints of the policyholder. We offer as an optional benefit the Accumulated Covered Expense (ACE) rider that provides for catastrophic coverage on our Scheduled/Basic plans for covered expenses under the contract that generally exceed $100,000 or, in certain cases, $75,000. The rider pays benefits at 100% after the stop loss amount is reached, up to the aggregate maximum amount of the contract for expenses covered by the rider.

Our CareOne Product Suite

In the first quarter of 2006, the Company introduced and began offering its new CareOne product portfolio to the self-employed and individual market. As CareOne products are approved in various states, the Company intends over time to replace its traditional health insurance product offerings with its new CareOne products.

The new CareOne product portfolio includes a new Basic Medical/Surgical Expense Plan, two versions of a Catastrophic Expense PPO Plan and two versions of a Catastrophic Expense Consumer Guided Health Plan:

The CareOne Value Plan is a new Basic Medical/Surgical Expense Plan with a $2.0 million lifetime benefit for all injuries and sicknesses and $500,000 lifetime maximum benefit for each injury or sickness. Covered expenses are subject to a deductible and coinsurance. Covered inpatient and outpatient hospital charges are reimbursed up to pre-selected per-injury or sickness maximums. Surgeon, assistant surgeon, anesthesia, second surgical opinion, and ambulance services are also reimbursed to a scheduled maximum. Additional benefits are available through riders and include prescription drugs, emergency services and wellness care, among others. This type of health insurance policy is of a scheduled benefit nature, and as such, provides benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy. These limitations allow for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our more comprehensive policies. As of January 1, 2007, the CareOne Value Plan had been approved for issuance in 30 states.

The CareOne Plan is a new Catastrophic Expense PPO Plan and provides a $5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of $1.0 million. This plan incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. This plan imposes greater policyholder cost sharing if the policyholder uses providers outside of the PPO network. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 80% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. As a premium and cost savings measure, this new plan limits payment for diagnostic services (*e.g.* X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to an increase as overall hospital care expenses rise. As of January 1, 2007, the CareOne Plan had been approved for issuance in 32 states.

The CareOne Plus Plan is a second new Catastrophic Expense PPO Plan and provides a $5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of $1.0 million. This plan also incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided.

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This plan imposes greater policyholder cost sharing if the policyholder uses providers outside of the PPO network. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 80% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premium on these policies are subject to an increase as overall hospital care expenses rise. As of January 1, 2007, the CareOne Plus Plan had been approved for issuance in 32 states.

The CareOne Select Plan is a new Catastrophic Expense Consumer Guided Health Plan and provides a $5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of $1.0 million. This plan incorporates features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a Maximum Allowable Charge (MAC), which is the maximum fee payable under the policy for a particular healthcare service. As a premium and cost savings measure, this new plan limits payment for diagnostic services (e.g., X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our catastrophic PPO policies. As of January 1, 2007, the CareOne Select Plan had been approved for issuance in 31 states.

The CareOne Select Plus Plan is a second new Catastrophic Expense Consumer Guided Health Plan and provides a $5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of $1.0 million. This plan also incorporates features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a MAC. The MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our catastrophic PPO policies. As of January 1, 2007, the CareOne Select Plus Plan had been approved for issuance in 31 states.

These products are issued and sold by our subsidiaries, MEGA and Mid-West, and are distributed by independent agents associated with MEGA s UGA Association Field Services and Mid-West s Cornerstone America marketing divisions.

Consumer Guided Health Plan Products

In the first quarter of 2005, we began to offer on a selective state-by-state basis a new suite of consumer guided health plans for the individual market. The Company s consumer guided health plans incorporate features that enable consumers to assume a greater role in making healthcare decisions. Information is published on the internet and is available through customer support via the telephone to assist our customers in obtaining access to information about their benefits and healthcare provider cost and quality. The Company s initial consumer guided health plan offerings called the Consumer Preference Plan and the Smart Consumer Plan were available in various states during 2005 and 2006, but are no longer available for purchase. These products were issued and sold by our subsidiary, MEGA, and were distributed by independent agents associated with MEGA s UGA-Association Field Services marketing division.

2007 New Product Introductions

In the second quarter of 2007, we will introduce a new portfolio of Health Savings Account (HSA) qualified High Deductible Health Plans (HDHPs) to the self-employed market. This new product portfolio will include two new products a PPO-based HSA-qualified product and a Consumer Guided Health Plan-based HSA-qualified product:

Our new PPO-based HSA-Qualified HDHPs have a $5.0 million lifetime maximum benefit for all injuries and sicknesses and a maximum benefit per year of $1.0 million. This plan incorporates features of a

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preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 100% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the calendar year. As an optional premium and cost savings measure, this plan can limit payment for diagnostic services (*e.g.* X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to increase as overall hospital care expenses rise.

Our new Consumer Guided Health Plan-based HSA-Qualified HDHPs have a $5.0 million lifetime maximum benefit for all injuries and sicknesses and a maximum benefit per year of $1.0 million. This plan incorporates features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a MAC, which is the maximum fee payable under the policy for a particular healthcare service. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 100% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the calendar year. As an optional premium and cost savings measure, this plan can limit payment for diagnostic services (*e.g.* X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be lower than future premium increases on our new PPO-based HSA-qualified product.

Subject to receipt of applicable regulatory approvals, the Company anticipates that these products will be issued and sold by our subsidiaries, MEGA and Mid-West, and will be distributed by independent agents associated with MEGA s UGA Association Field Services and Mid-West s Cornerstone America marketing divisions.

The Company evaluates new product offerings on an ongoing basis. In the future, we may offer new product lines, including but not limited to product lines focused on markets not traditionally served by the Company.

Ancillary Products

We have also developed and offer new ancillary product lines that provide protection against short-term disability, as well as a combination product that provides benefits for life, disability and critical illness. These products have been designed to further protect against risks to which our core customer is typically exposed.

Third Party Product Initiatives

During 2006, our subsidiaries, MEGA and Mid-West, entered into agreements to distribute health insurance products underwritten by other third-party insurance companies. The products sold under these arrangements focus on markets not traditionally served by the Company, including seniors and high risk customers. These products are distributed by independent insurance agents associated with MEGA s UGA-Association Field Services and Mid-West s Cornerstone America marketing divisions. To date, the Company has generated only nominal revenues from such arrangements.

Marketing and Sales

Substantially all of the health insurance products issued by our insurance company subsidiaries are sold through independent contractor agents. We believe that we have the largest direct selling organization in the health insurance field, with approximately 2,100 independent writing agents per week in the field selling health insurance to the individual and self employed market in 44 states.

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Our agents are independent contractors, and all compensation that agents receive from us for the sale of insurance is based upon the agents levels of sales production. UGA Association Field Services (UGA) and Cornerstone America (Cornerstone) (the principal marketing divisions of MEGA and Mid-West, respectively) are each organized into geographical regions, with each geographical region having a regional director, two additional levels of field leaders and writing agents (*i.e.,* the agents that are not involved in leadership of other agents).

UGA and Cornerstone are each responsible for the recruitment and training of their field leaders and writing agents. UGA and Cornerstone generally seek persons with previous sales experience. The process of recruiting agents is extremely competitive. We believe that the primary factors in successfully recruiting and retaining effective agents and field leaders are our practices regarding advances on commissions, the quality of the sales leads provided to agents, the availability and accessibility of equity ownership plans, the quality of the products offered, proper training, and agent incentives and support. Classroom and field training with respect to product content is required and made available to the agents under the direction of our regulated insurance subsidiaries.

We provide health insurance products to consumers in the individual and self-employed market in 44 states. As is the case with many of our competitors in this market, a substantial portion of our products is issued to members of various independent membership associations that act as the master policyholder for such products. The two principal membership associations in the self-employed market that make available to their members our health insurance products are the National Association for the Self-Employed and the Alliance for Affordable Services. The associations provide their membership access to a number of benefits and products, including health insurance underwritten by us. Subject to applicable state law, individuals generally may not obtain insurance under an association s master policy unless they are also members of the association. The agreements with these associations requiring the associations to continue as the master policyholder for our policies and to make our products available to their respective members are terminable by us and the associations upon not less than one year s advance notice to the other party. While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing so-called association group insurance (particularly changes that would subject the issuance of policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis) could have a material adverse impact on our financial condition, results of operations and/or business.

UGA agents and Cornerstone agents also act as field service representatives (FSRs) for the associations. In this capacity the FSRs enroll new association members and provide membership retention services. For such services, we and the FSRs receive compensation. Specialized Association Services, Inc. (a company controlled by the adult children of the late Ronald L. Jensen, the Company s former Chairman) provides administrative and benefit procurement services to the associations. One of our subsidiaries, HealthMarkets Lead Marketing Group Inc. (formerly known as UICI Marketing, Inc.), serves as our direct marketing group and generates new membership sales prospect leads for both UGA and Cornerstone for use by the FSRs (agents). HealthMarkets Lead Marketing Group also provides video and print services to the associations and to Specialized Association Services, Inc. *See* Note O of Notes to Consolidated Financial Statements. In addition to health insurance premiums derived from the sale of health insurance, we receive fee income from the associations, including fees associated with enrollment and member retention services, fees for association membership marketing and administrative services and fees for certain association member benefits.

HealthMarkets Lead Marketing Group, Inc. generates sales prospect leads for UGA and Cornerstone for use by their agents. HealthMarkets Lead Marketing Group administers a call center (located in Oklahoma City, Oklahoma) staffing approximately 80 tele-service representatives. Leads are also obtained from third party data sources. HealthMarkets Lead Marketing Group has developed a marketing pool of approximately fifteen million prospects from various data sources. Prospects initially identified by HealthMarkets Lead Marketing Group that are

self-employed, small business owners or individuals may become a qualified lead by responding through one of HealthMarkets Lead Marketing Group s lead channels and by expressing an interest in learning more about health insurance. We believe that UGA and Cornerstone agents, possessing the qualified leads contact information, are able to achieve a higher close rate than is the case with unqualified prospects.

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Policy Design and Claims Management

Our health insurance products are principally designed to limit coverages to the occurrence of significant events that require hospitalization. This policy design, which includes high deductibles, reduces the number of covered claims requiring processing, thereby serving as a control on administrative expenses. We seek to price our products in a manner that accurately reflects our underwriting assumptions and targeted margins, and we rely on the marketing capabilities of our dedicated agency sales forces to sell these products at prices consistent with these objectives.

We maintain administrative centers with full underwriting, claims management and administrative capabilities. We believe that by processing our own claims we can better assure that claims are properly processed and can utilize the claims information to periodically modify the benefits and coverages afforded under our policies.

We have also developed an actuarial data warehouse, which is a critical risk management tool that provides our actuaries with rapid access to detailed exposure, claim and premium data. This analysis tool enhances the actuaries ability to design, monitor and adequately price all of the Self-Employed Agency Division s insurance products.

Provider Network Arrangements and Cost Management Measures

The Company makes available to customers access to selected PPO provider networks so that customers may obtain discounts on provider services that would otherwise not be available. Provider networks are made available on a regional basis, based on the coverage and discounts available within a particular geographic region. In situations where a customer does not obtain services from a contracted provider, the Company applies various usual and customary fees, which limit the amount paid to providers within specific geographic areas.

We believe that access to provider network contracts is a critical factor in controlling medical costs, since there is often a significant difference between a network-negotiated rate and the non-discounted rate. To this end, we access networks of hospitals and physicians through a variety of relationships with third party network providers. During 2006, approximately 84% of submitted claims were adjudicated through provider networks. Of the claims adjudicated through provider networks, approximately 79% were submitted through a primary provider network contract and approximately 5% were submitted through a supplemental network utilized if savings are not achieved through the primary network. In addition, we have retained a pharmacy benefits management company that has approximately 61,000 participating pharmacies nationwide. We also utilize co-payments, coinsurance, deductibles and annual limits to manage prescription drug costs.

The Company utilizes other means to control medical costs, including providing customers with access to supplemental network discounts if savings are not obtained through a primary provider network contract and use of pre- and post-payment fee negotiation services and claim editing services.

Products for the Small Employer Group Market

In the first quarter of 2005, we began to offer our Consumer Advantage Plan to small (2-50 members) employer group consumers in selected urban markets in Texas, Georgia and Michigan. At January 1, 2007, the Consumer Advantage Plan had also been approved for issuance in Alabama, Arizona, Arkansas, Illinois, Missouri, Nevada, Ohio and Tennessee. These products are issued and sold by our subsidiary, The MEGA Life and Health Insurance Company, and distributed by independent agents associated with our UGA Association Field Services marketing division.

To date, the Company has generated only nominal revenues from the sale of health insurance products to the small employer group market.

Life Insurance Division

Our Life Insurance Division offers life insurance products to individuals. At December 31, 2006, the Life Insurance Division (which is based in Oklahoma City, Oklahoma) had nearly $6.9 billion of net life insurance in force and over 296,000 individual policyholders. The Life Insurance Division generated revenues of $87.8 million,

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$83.0 million and $67.6 million (representing 4%, 4% and 3% of our total revenue) in 2006, 2005 and 2004, respectively.

Markets Served

The Life Insurance Division offers its life insurance products to demographically growing market segments that we have identified as underserved, including the self-employed market, the middle-income market, the Hispanic market and the senior market.

Products

The Life Insurance Division s products are tailored to meet the specific needs of customers in each of its targeted markets. We offer universal life insurance and term life insurance products to individuals in the self-employed market. We offer two other universal life insurance products and other term life insurance products to meet the needs of individuals in the middle-income and the Hispanic markets. We also offer whole life insurance products (level, graded and modified) to assist seniors in meeting their needs to cover final expenses.

Distribution

The Life Insurance Division distributes its insurance products primarily through internal and external distribution channels. Commencing in the second quarter of 2002, our UGA and Cornerstone agents began to market our universal life insurance and term life insurance products to individuals in the self-employed market. In 2003, the Life Insurance Division also entered into new marketing relationships with two independent marketing companies to distribute our universal life insurance, term life insurance and whole life insurance products through networks of managing general agents (MGAs). One marketing company offers universal life insurance and term life insurance products to middle-income buyers and through agencies that specialize in sales to Hispanic buyers. The second marketing company offers our whole life insurance product line exclusively for seniors. At year-end 2006, these two marketing organizations had contracted over 13,000 independent agents to distribute our products.

Marketing and Sales

With the help of agents associated with UGA and Cornerstone, the Life Insurance Division seeks to leverage our significant health insurance customer base by positioning itself to offer those customers (self-employed individuals) universal life insurance and term life insurance products designed to fit their changing needs. The two independent marketing companies that we have contracted with offer universal life insurance and term life insurance product lines through their agents to cover the needs of the middle-income market, the Hispanic market and the senior market. The Life Insurance Division has also developed a needs analysis software selling system, Blueprint for Life® . This selling tool allows the agent to accurately and quickly identify the amount of insurance that should be carried by an individual. We believe that the Blueprint for Life® provides a much needed and valuable service to the middle-income buyer, who has often been overlooked or underserved by other distributors of life insurance products.

Other Insurance

Through our 82.5%-owned subsidiary, ZON Re USA LLC (ZON Re), we underwrite, administer and issue accidental death, accidental death and dismemberment (AD&D), accident medical and accident disability insurance products, both on a primary and on a reinsurance basis. In the year ended December 31, 2006, ZON Re generated revenues of $35.3 million and operating income of $5.5 million.

ZON Re underwrites and manages a portfolio of personal accident reinsurance programs on behalf of MEGA for primary life, accident and health and property and casualty insurers that wish to transfer risks associated with certain types of primary personal accident insurance programs. Accident reinsurance provides reimbursement to primary insurance carriers for covered losses resulting from accidental bodily injury or accidental death. For its reinsurance clients, ZON Re targets national, regional and middle market insurers in the United States and Canada. ZON Re distributes accident reinsurance products through a network of professional reinsurance intermediaries. ZON Re underwrites both treaty and facultative accident reinsurance programs, which may be offered on either a

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quota share or excess of loss basis. The Company has determined, as a matter of policy, that MEGA s exposure on any single reinsurance contract issued by it and underwritten by ZON Re will not exceed $1.0 million per person and $10.0 million per event.

ZON Re also underwrites and distributes a limited portfolio of primary accident insurance products issued by Chesapeake. These products are designed for direct purchase by banks, associations, employers and affinity groups and are distributed through a national network of independent commercial insurance agents, brokers and third party administrators (TPAs). The Company has determined, as a matter of policy, that Chesapeake s maximum exposure on any single primary insurance contract issued by it and underwritten by ZON Re will not exceed $1.0 million per person.

Ceded Reinsurance

Our insurance subsidiaries reinsure portions of the coverages provided by their insurance products with other insurance companies on both an excess-of-loss and coinsurance basis. The maximum retention by us on one individual in the case of life insurance is $200,000 for MEGA, Mid-West and Chesapeake. We use reinsurance for our health insurance business solely for limited purposes. Reinsurance agreements are intended to limit an insurer s maximum loss.

Competition

In each of our lines of business, we compete with other insurance companies or service providers, depending on the line and product, although we have no single competitor who competes against us in all of the business lines in which we operate. With respect to the business of our Self-Employed Agency Division, the market is characterized by many competitors, and our main competitors include health insurance companies, health maintenance organizations and the Blue Cross/Blue Shield plans in the states in which we write business. While we are among the largest competitors in terms of market share in some of our business lines, in some cases there are one or more major market players in a particular line of business.

Competition in our businesses is based on many factors, including quality of service, product features, price, scope of distribution, scale, financial strength ratings and name recognition. We compete, and will continue to compete, for customers and distributors with many insurance companies and other financial services companies. We compete not only for business and individual customers, employer and other group customers, but also for agents and distribution relationships. Some of our competitors may offer a broader array of products than our specific subsidiaries with which they compete in particular markets, may have a greater diversity of distribution resources, may have better brand recognition, may from time to time have more competitive pricing, may have lower cost structures or, with respect to insurers, may have higher financial strength or claims paying ratings. Organizations with sizable market share or provider-owned plans may be able to obtain favorable financial arrangements from healthcare providers that are not available to us. Some may also have greater financial resources with which to compete. In addition, from time to time, companies enter and exit the markets in which we operate, thereby increasing competition at times when there are new entrants. For example, several large insurance companies have recently entered the market for individual health insurance products and/or consumer guided health plans. We may lose business to competitors offering competitive products at lower prices, or for other reasons, which could materially adversely affect our future results of operations and financial condition.

Regulatory and Legislative Matters

Insurance Regulation

State Regulation General

Our insurance subsidiaries are subject to extensive regulation in their states of domicile and the other states in which they do business under statutes that typically delegate broad regulatory, supervisory and administrative powers to insurance departments. The method of regulation varies, but the subject matter of such regulation covers, among other things, the amount of dividends and other distributions that can be paid by the insurance subsidiaries without prior approval or notification; the granting and revoking of licenses to transact business; trade practices,

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including with respect to the protection of consumers; disclosure requirements; privacy standards; minimum loss ratios; premium rate regulation; underwriting standards; approval of policy forms; claims payment; licensing of insurance agents and the regulation of their conduct; the amount and type of investments that the insurance subsidiaries may hold, minimum reserve and surplus requirements; risk-based capital requirements; and compelled participation in, and assessments in connection with, risk sharing pools and guaranty funds. Such regulation is intended to protect policyholders rather than investors.

State regulation of health insurance products varies from state to state, although all states regulate premium rates, policy forms and underwriting and claims practices to one degree or another. Most states have special rules for health insurance sold to individuals and small groups. For example, a number of states have passed or are considering legislation that would limit the differentials in rates that insurers could charge for healthcare coverage between new business and renewal business for small groups with similar demographics. Every state has also adopted legislation that would make health insurance available to all small employer groups by requiring coverage of all employees and their dependents, by limiting the applicability of pre-existing conditions exclusions, by requiring insurers to offer a basic plan exempt from certain benefits as well as a standard plan, or by establishing a mechanism to spread the risk of high risk employees to all small group insurers.

Various states have from time to time proposed and/or enacted changes to the healthcare system that could affect the relationship between health insurers and their customers. For example, on April 12, 2006, Massachusetts enacted healthcare reform legislation intended to provide healthcare coverage to previously uninsured residents of Massachusetts. Effective July 1, 2007, the law requires all residents to obtain minimum levels of health insurance and requires employers with 11 or more full time employees to pay an assessment if they do not offer health insurance to these employees. The law also establishes the Commonwealth Health Insurance Connector (Connector), through which individuals and small businesses may obtain health insurance directly from the Connector. Our insurance subsidiaries, MEGA and Mid-West, submitted bids to sell products through the Connector, but were not among the companies selected to participate in the Connector. We intend to continue selling health insurance in Massachusetts outside the Connector. In addition, various other states are considering the adoption of play or pay laws requiring that employers either offer health insurance or pay a tax to cover the costs of public healthcare insurance. We cannot predict with certainty the effect that the Massachusetts law, or proposed legislation in other states, if adopted, could have on our insurance businesses and operations.

A number of states have enacted other new health insurance legislation over the past several years. These laws, among other things, mandate benefits with respect to certain diseases or medical procedures, require health insurers to offer an independent external review of certain coverage decisions and establish health insurer liability. There has also been an increase in legislation regarding, among other things, prompt payment of claims, privacy of personal health information, health insurer liability, prohibition against insurers including discretionary clauses in their policy forms and relationships between health insurers and providers. We expect that this trend of increased legislation will continue. These laws may have the effect of increasing our costs and expenses.

We provide health insurance products to consumers in the individual and self-employed market in 44 states. As is the case with many of our competitors in this market, a substantial portion of our products is issued to members of various independent membership associations that act as the master policyholder for such products. During 2004, we, and our insurance company subsidiaries, resolved a nationwide class action lawsuit challenging the nature of the relationship between our insurance companies and the membership associations that make available to their members our insurance companies health insurance products. A number of additional lawsuits challenging the nature of the relationship between our insurance companies and such membership associations are ongoing. *See* Note P of Notes to Consolidated Financial Statements. While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing association group insurance (particularly changes that would subject the issuance of

policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis) could have a material adverse impact on our financial condition, results of operations and/or business.

Many states have also enacted insurance holding company laws that require registration and periodic reporting by insurance companies controlled by other corporations. Such laws vary from state to state, but typically require

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periodic disclosure concerning the corporation that controls the controlled insurer and prior notice to, or approval by, the applicable regulator of inter-corporate transfers of assets and other transactions (including payments of dividends in excess of specified amounts by the controlled insurer) within the holding company system. Such laws often also require the prior approval for the acquisition of a significant ownership interest (i.e., 10% or more) in the insurance holding company. HealthMarkets (the holding company) and our insurance subsidiaries are subject to such laws, and we believe that we and such subsidiaries are in compliance in all material respects with all applicable insurance holding company laws and regulations.

Under the risk-based capital initiatives adopted in 1992 by the National Association of Insurance Commissioners (NAIC), insurance companies must calculate and report information under a risk-based capital formula. Risk-based capital formulas are intended to evaluate risks associated with asset quality, adverse insurance experience, losses from asset and liability mismatching, and general business hazards. This information is intended to permit regulators to identify and require remedial action for inadequately capitalized insurance companies, but it is not designed to rank adequately capitalized companies. At December 31, 2006, the risk-based capital ratio of each of our domestic insurance subsidiaries significantly exceeded the ratio for which regulatory corrective action would be required.

The states in which our insurance subsidiaries are licensed have the authority to change the minimum mandated statutory loss ratios to which they are subject, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced. Loss ratios are commonly defined as incurred claims as a percentage of earned premiums. Most states in which our insurance subsidiaries write insurance have adopted the minimum loss ratios recommended by the NAIC, but frequently the loss ratio regulations do not apply to the types of health insurance issued by our subsidiaries. A number of states are considering the adoption of, or have adopted, laws that would mandate minimum statutory loss ratios, or increase existing minimum statutory loss ratios, for the products we offer. For example, on July 1, 2007, California regulations will become effective that will require a minimum medical loss ratio of 70% for health insurance issued after that date, as well as business issued prior to that date if it is subject to a rate revision. We are unable to predict the impact of (i) any changes in the mandatory statutory loss ratios for individual or group policies to which we may become subject, or (ii) any change in the manner in which these minimums are computed or enforced in the future. Such changes could result in a narrowing of profit margins and adversely affect our business and results of operations. We have not been informed by any state that our insurance subsidiaries do not meet mandated minimum ratios, and we believe that we are in compliance with all such minimum ratios. We have filed new products intended to address the California minimum medical loss ratio requirements that will become effective on July 1, 2007. Our ability to offer these products is subject to receipt of applicable regulatory approvals, and there can be no assurance that approvals will be received. In the event that we are not in compliance with minimum statutory loss ratios mandated by regulatory authorities with respect to certain policies, we may be required to reduce or refund premiums, which could have a material adverse effect upon our business and results of operations.

The NAIC and state insurance departments are continually reexamining existing laws and regulations, including those related to reducing the risk of insolvency and related accreditation standards. To date, the increase in solvency-related oversight has not had a significant impact on our insurance business.

State Regulation Financial and Market Conduct Examinations

Our insurance subsidiaries are required to file detailed annual statements with the state insurance regulatory departments and are subject to periodic financial and market conduct examinations by such departments. The most recently completed financial examination of MEGA in Oklahoma (MEGA s domicile state) was completed as of and for the two-year period ended December 31, 2003. The most recently completed financial examination of Mid-West in Tennessee (Mid-West s state of domicile until October 2005) was completed as of and for the three-year period ended December 31, 2003. The most recently completed financial examination of Chesapeake in Oklahoma (Chesapeake s

domicile state) was completed as of and for the three-year period ended December 31, 2003. In the first quarter of 2007, the Oklahoma Department of Insurance commenced financial examinations of MEGA and Chesapeake for the three-year period ended December 31, 2006 and the Texas Department of Insurance (Mid-West s state of domicile since October 2005) commenced a financial examination of Mid-West for the three-year period ended December 31, 2006. The examinations are ongoing.

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State insurance departments have also periodically conducted and continue to conduct market conduct examinations of HealthMarkets insurance subsidiaries. In March 2005, HealthMarkets received notification that the Market Analysis Working Group of the National Association of Insurance Commissioners had chosen the states of Washington and Alaska to lead a multi-state market conduct examination of HealthMarkets principal insurance subsidiaries. We believe that approximately 34 states have elected to participate in the examination, which commenced in May 2005 and is ongoing. The examiners have completed the onsite phases of the examination. An exit interview was held on July 17, 2006, in which representatives of the lead states and the Company participated. The Company expects to receive a draft of the examination report in the near future and will respond to the draft report in a timely manner. While we do not currently believe that the multi-state market conduct examination will have a material adverse effect upon our consolidated financial position or results of operations, state insurance regulatory agencies have authority to levy monetary fines and penalties resulting from findings made during the course of such examinations.

In addition to the multi-state market conduct examination, as of December 31, 2006, MEGA, Mid-West and/or Chesapeake were subject to ongoing market conduct examinations and/or open inquiries with respect to marketing practices in 8 states. State insurance regulatory agencies have authority to levy monetary fines and penalties resulting from findings made during the course of such market conduct examinations. Historically, our insurance subsidiaries have from time to time been subject to such fines and penalties, none of which individually or in the aggregate have had a material adverse effect on our results of operations or financial condition.

On December 6, 2006, MEGA, Mid-West and Chesapeake, entered into a settlement agreement with the Massachusetts Division of Insurance (MA DOI) upon the conclusion of a market conduct examination by the MA DOI covering the period January 1, 2002 to December 31, 2004. The examination consisted of a review of the operations of MEGA, Mid-West and Chesapeake for small group health insurance issued to Massachusetts certificate holders during the examination period. The settlement agreement provides, among other things, for changes in certain Company operations and procedures, including those related to claims handling, complaints and grievances, marketing and sales and underwriting. In addition, MEGA, Mid-West and Chesapeake agreed to conduct a claims reassessment process, pursuant to which the companies are contacting Massachusetts claimants and offering to reassess certain denied claims based on specific codes identified by the MA DOI. The reassessment covers claims for the period January 1, 2002 through December 31, 2004, as well as claims on certificates issued through April 30, 2005 or renewed through July 31, 2005 to the date of their first renewal or lapse. The MA DOI will not impose fines or take other action against the Company unless the Company fails to complete the required actions set forth in the settlement agreement or unless additional material information related to the required actions becomes available to the MA DOI. In entering the settlement, the Company did not admit, deny or concede any actual or potential fault, wrongdoing, liability or violation of law. The Company believes that the terms of the settlement will not have a material adverse effect upon the financial condition or results of operations of the Company.

Federal Regulation

In 1945, the U.S. Congress enacted the McCarran-Ferguson Act, which declared the regulation of insurance to be primarily the responsibility of the individual states. Although repeal of McCarran-Ferguson is debated in the U.S. Congress from time to time, the federal government generally does not directly regulate the insurance business. However, federal legislation and administrative policies in several areas, including healthcare, pension regulation, age and sex discrimination, financial services regulation, securities regulation, privacy laws, terrorism and federal taxation, do affect the insurance business.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As with other lines of insurance, the regulation of health insurance historically has been within the domain of the states. However, HIPAA and the implementing regulations promulgated thereunder by the Department of Health and Human Services impose obligations for issuers of health and dental insurance coverage and health and dental benefit plan sponsors. HIPAA requires certain guaranteed issuance and renewability of health insurance coverage for individuals and small employer groups (generally 50 or fewer employees) and limits exclusions based on pre-existing conditions. Most of the insurance reform provisions of HIPAA became effective for plan years beginning on or after July 1, 1997.

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HIPAA also establishes requirements for maintaining the confidentiality and security of individually identifiable health information and new standards for electronic healthcare transactions. The Department of Health and Human Services promulgated final HIPAA regulations in 2002. The privacy regulations required compliance by April 2003, the electronic transactions regulations by October 2003, and the security regulations by April 2005. As have other entities in the healthcare industry, we have incurred substantial costs in meeting the requirements of these HIPAA regulations and expect to continue to incur costs to maintain compliance. We have worked diligently to comply with these regulations within the time periods required and believe that we have complied.

HIPAA is a far-reaching and complex issue and proper interpretation and practice under the law continue to evolve. Consequently, our efforts to measure, monitor and adjust our business practices to comply with HIPAA are ongoing. Failure to comply could result in regulatory fines and civil lawsuits. Knowing and intentional violations of these rules may also result in federal criminal penalties.

HealthMarkets is continuously reviewing the potential impact of the HIPAA privacy and security regulations on its operations, including its information technology and security systems. There can be no assurance that the restrictions and duties imposed by the final rules on the privacy and security of individually-identifiable health information will not have a material adverse effect on HealthMarkets business and future results of operations.

USA PATRIOT Act

On October 26, 2001, the International Money Laundering Abatement and Anti-Terrorist Financing Act of 2001 was enacted into law as part of the USA PATRIOT Act. The law requires, among other things, that financial institutions adopt anti-money laundering programs that include policies, procedures and controls to detect and prevent money laundering, designate a compliance officer to oversee the program and provide for employee training, and periodic audits in accordance with regulations proposed by the U.S. Treasury Department. Treasury regulations governing portions of our life insurance business require that we maintain procedures designed to detect and prevent money laundering and terrorist financing. We remain subject to U.S. regulations that prohibit business dealings with entities identified as threats to national security. We have licensed software to enable us to detect and prevent such activities in compliance with existing regulations and we are developing policies and procedures designed to comply with the proposed regulations should they come into effect.

There are significant criminal and civil penalties that can be imposed for violation of Treasury regulations. We believe that the steps we are taking to comply with the current regulations and to prepare for compliance with the proposed regulations should be sufficient to minimize the risks of such penalties.

CAN SPAM Act

From time to time the Company utilizes, either directly or through third party vendors, e-mail to identify prospective sales leads for use by its agents. The federal CAN SPAM Act, which became effective January 1, 2004 and is administered and enforced by the Federal Trade Commission, establishes national standards for sending bulk, unsolicited commercial e-mail. While targeting and prohibiting