Adopted: December 11, 1990
Effective: February 15, 1991
Amended: March 11, 2004
Amended: October 5, 2006
Amended: December 8, 2011

MEMORANDUM OF UNDERSTANDING
GENERAL LIABILITY PROGRAM II

This Memorandum of Understanding is entered into by and between the CSAC-EIA (hereinafter referred to as the "Authority") and the participating members of the General Liability Program II (hereinafter referred to as “GLII”), consisting of counties and other public entities (hereinafter “Public Entity”) who are signatories to this Memorandum.

1. **JOINT POWERS AGREEMENT**. Except as otherwise provided herein, all terms used herein shall be as defined in Article 1 of the 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. **PROGRAM COMMITTEE**.

A. There is hereby established a GLII Program Committee (hereinafter referred to as "GLII Committee" or “Committee”) and, except as otherwise provided herein, said Committee shall have full authority to determine all matters affecting the participating members.

B. The GLII Committee shall consist of all GLII member counties of the Authority, with the committee member being that person designated as the county’s Board member for the Authority. In the event a county Committee member is not present at a meeting of the Committee, the County’s Alternate Board member may serve as the county’s alternate on the Committee. In addition to GLII member counties, each GLII public entity member shall be a member of the Committee, subject to the GLII member counties maintaining a minimum of 60% of the eligible voting membership on the Committee. The GLII public entity committee members shall be reduced accordingly to ensure at least 60% of the Committee consists of GLII member counties. For example, based upon the 8 current GLII member counties participating in the program, all 3 current GLII public entity members would have a seat on the Committee and maintain at least 60% representation by the GLII member counties. If the number of GLII member counties is reduced to 4, then the GLII public entity members would lose one seat and have only 2 votes. GLII public entity committee members shall be appointed by the Executive Committee and shall serve for a two year term. Each GLII public entity committee member shall designate an alternate to vote in their absence. The alternate must be an employee or elected or appointed official of the GLII public entity committee member.

C. The GLII Committee shall meet on the call of the Chair of the Committee as provided in Article 12 of the Agreement and Article VI of the Bylaws of the Authority (hereinafter referred to as the "Bylaws").

D. A majority of the members of the GLII Committee shall constitute a quorum for the transaction of business. Except as otherwise provided herein, all actions of the GLII Committee shall require the affirmative vote of a majority of the members of the Committee. Any meeting of the GLII Committee shall be subject to the applicable provisions of Government Code § 54950 et seq., commonly known as the "Brown Act."

3. **PREMIUMS**. The participating members, in accordance with the provisions of Article 14 of the Agreement, shall be assessed an annual premium for the purpose of funding the GLII Program. Annual premium contributions, including Program administrative costs plus the Authority's general expense allocated to the Program by the Board for the next policy period, shall be as established by the GLII Committee upon consultation with the underwriters.

4. **MEMBER SELF-INSURED RETENTIONS.** The self-insured retention amounts of the members shall be established upon consultation with the underwriters and subject to approval by the GLII Committee.

5. **COST ALLOCATION.** The method of allocating contributions to the GLII Program shall be determined by the GLII Committee upon consultation with underwriters.

6. **FUNDING FOR CLAIMS**.

A. At the GLII Committee's discretion, based on market conditions, exposures, and/or loss history, self-insured layers or aggregated retentions may be established for the GLII Program for any policy period or combination of policy periods. If self-insured and/or aggregated retention layers are established, such will be funded by contributions from the members participating in the self-insured and/or aggregated retention layers, as determined by the Committee. Funding for these layers shall be used exclusively for the payment of claims made against the participating members, including expenses, in accordance with the terms and conditions of the applicable Memorandum of Coverage.

B. Any self-insured and/or aggregated retention layers shall be fully funded by the participating members, and may, at the discretion of the GLII Committee, be discounted for anticipated and/or earned investment earnings. Should such not be fully funded for any reason, pro-rata assessments may be made to the participating members pursuant to the provisions of Article 14.b.3. of the Agreement to ensure a 100% funding level.

7. **DIVIDENDS**. Notwithstanding Article 22.b. of the Agreement, if self-insured and/or aggregated retention layers are established and it is determined that funds remain after the payment of all claims, a dividend may be declared by the GLII Committee. If a dividend is declared, the dividend shall be payable to the members participating in the layer, during the period in which there are excess funds, based on each member's share

of contributions to the applicable layer, regardless of whether the member is a participating member in the GLII Program at the time the dividend is declared.

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

9. **CLAIMS ADMINISTRATION.** Each participating member is required to 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 A and incorporated herein.

10. **APPLICATION TO THE PROGRAM**.

A. All applications to join the GLII Program will be evaluated by and subject to approval by the GLII Committee and the underwriter.

B. Any entity which makes application to become a participating member of the GLII Program who is not already a participating member in the Authority must also be approved in accordance with the provisions of Article 19 of the Agreement.

C. New participating members may be added to the GLII Program during the term of the coverage period on a pro-rata basis. Notwithstanding late entry into the Program, the new member may be assessed additional sums pursuant to paragraph 6 herein, based upon all claims against the fund during the entire coverage period.

11. **WITHDRAWAL AND/OR CANCELLATION FROM THE PROGRAM**. Withdrawal and/or cancellation of a member from the GLII Program shall be in accordance with the provisions of Article 20 or 21 of the Agreement, except that any interest or other dividend to which the withdrawing member is otherwise entitled shall be payable to the withdrawing member in accordance with paragraph 7 herein.

12. **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.

13. **RESOLUTION 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 Article 31 of the Agreement, and may also be subject to approval of the underwriter.

14. **AMENDMENT**. This Memorandum may be amended by a majority vote of the GLII Committee and signature on the Memorandum by the member's designated representative who shall have authority to execute this Memorandum. Should a member

of the GLII Program fail to execute any amendment to this Memorandum within the time provided by the GLII Committee, the member will be deemed to have withdrawn as of the end of the policy period.

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

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

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

18. **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 whereof, the undersigned have executed this Memorandum as of the date set forth below.

Dated: 12/8/11 _____
CSAC Excess Insurance Authority

Dated: _____ _____

Name, Position: _____

Member Entity: _____

EXHIBIT A

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.

ADDENDUM TO EXHIBIT A

Adopted: December 6, 1985
Amended: January 23, 1987
Amended: October 6, 1995
Amended: October 1, 1999
Amended: March 2, 2007
Amended: March 5, 2010

ADDENDUM B
LIABILITY
CLAIMS ADMINISTRATION GUIDELINES

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

I. CLAIMS INVESTIGATION

A. Complete factual investigation shall be done 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. Initiate the development of 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 shall be given to structured settlements and Voluntary Settlement Conferences. The Authority 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. Report all bodily injury claims to the Index Bureau.

1. The Authority maintains membership in the Index Bureau that members can access.
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.

Claims are reported via the internet. An instruction manual may be obtained online at Claimsearch.iso.com, after being registered for use by the Authority

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

In the event of an **occurrence** or a **wrongful act** reasonably likely to involve the Authority, written notice containing particulars sufficient to identify the **covered party** and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the **covered party** to the Authority or any of its authorized agents as soon as practicable, after the individual responsible for the coverage at the Member, or his/her designee, has knowledge of the **occurrence** or **wrongful act**.

Utilize the current First Report Potential Excess Liability Claims form, available through the Authority website, and transmit to the Authority.

The Member shall give the Authority immediate written notice for any claims or suits which the Member becomes aware of that include injury of the following types:

a. Death

b. Paralysis, paraplegia, quadriplegia
c. Loss of eye(s), or limbs
d. Spinal cord or brain injury
e. Dismemberment or amputation
f. Sensory organ or nerve injury or neurological deficit
g. Serious burns
h. Severe scarring
i. Sexual assault or battery including but not limited to rape, molestation or sexual abuse
j. Substantial disability or disfigurement
k. Any class action
l. Any claim with trial within nine (9) months and demand of $1 million or more
m. Any **occurrence** or **wrongful act** with total incurred (combination of paid and outstanding reserves) at or above the lesser of $500,000 or 50% of the Member's Retained Limit

B. Update Reports

The Authority shall be provided copies of periodic reports (at least every 90 days) in order to be kept apprised of the developments of the case. On litigated cases, defense counsel shall also include the Authority on their mailing lists for copies of correspondence, reports, evaluations, interrogatory summaries, deposition summaries and medical summaries. Actual deposition transcripts, interrogatories, their answers to interrogatories and interim billings are not required.

As reserve/update changes occur, complete and transmit the current Reserve and Payment Update form available through the Authority website.

C. Closure Reports

When a case that has been reported to the Authority is settled, dismissed or closed in any other fashion, provide the Authority with the closing documents and a completed current Closure Information form, available through the Authority 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 shall be made for failure to meet the applicable Code of Civil Procedure statutes for timely serving, conducting discovery or bringing a complaint to trial.

C. Proper verification of a claimant's status as to Medicare eligibility shall be completed and documented in every file involving a bodily injury. In those cases where the claimant does meet the eligibility requirements, mandatory reporting to the Center for Medicare and Medicaid Services (CMS) must be completed directly or through a reporting agent in compliance with State Children's Health Insurance Program (SCHIP) Section 111.

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 shall 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 shall 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 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 Authority's excess reporting requirements regardless of reserves.

Members and/or claims administrators may follow stricter guidelines.

The captioned report shall 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
23. Medicare eligibility and reporting

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 manner.

V. CASE SETTLEMENT FACTORS

A. The settlement shall be reasonable in light of damages, injuries, liability, and any obligations to Medicare.

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

C. Contributions from joint tort feasors shall 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 Authority.

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's initial evaluation shall be completed and in the file within sixty (60) days of assignment.

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

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

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

F. Litigation outcome and total costs shall be documented.

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

VII. SUMMARY

The file shall be completely documented. Audits conducted by the Authority Auditor shall measure whether performance is consistent with these guidelines.