UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

IN RE: EMPLOYEE BENEFIT INSURANCE BROKERAGE ANTITRUST LITIGATION	:	MDL No. 1663
	:	Civil No. 05-1079 (GEB)
APPLIES TO ALL EMPLOYEE BENEFIT ACTIONS	:	Hon. Garrett E. Brown
	:	JURY TRIAL DEMANDED.

THIRD AMENDED EMPLOYEE BENEFITS PLAINTIFFS' RICO CASE STATEMENT PURSUANT TO LOCAL RULE 16.1(B)(4)

Pursuant to the Court's Order of April 5,[1] Plaintiffs submit this Third Amended RICO Case Statement under Local Civil Rule 16.1(B)(4).

1. State whether the alleged unlawful conduct is in violation of 18 U.S.C. § 1962(a), (b), (c) and/or (d).

Plaintiffs assert violations of 18 U.S.C. § 1962(c) and 18 U.S.C. § 1962(d). There is no alleged violation of 18 U.S.C. § 1962(a) or 18 U.S.C. § 1962(b).

2. List each defendant and state the alleged misconduct and basis of liability of each defendant.

The Marsh Enterprise Defendants

Marsh[2] and AIG[3], CIGNA[4], Hartford[5], MetLife[6], Prudential[7] and UnumProvident[8] (collectively the "Marsh Enterprise Defendants") formed an association in fact enterprise (the

[1] Pursuant to Order No. 1, dated March 11, 2005, Plaintiffs previously submitted a Joint RICO Case Statement, which addressed both commercial insurance allegations and employee benefit allegations. Plaintiffs submitted an Amended RICO Case Statement on August 15, 2005. Likewise, pursuant to an Order dated October 3, 2006, Plaintiffs submitted a Second Amended RICO Case Statement on October 25, 2006.

[2] "Marsh" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

[3] "AIG" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

[4] "CIGNA" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

[5] "Hartford" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

[6] "MetLife" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

[7] "Prudential" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

[8] "Unum" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

Marsh enterprise) and participated in or conducted the affairs of the Marsh enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c), utilizing interstate mail and wire in furtherance of the scheme, as well as undertaking the unlawful influence of ERISA governed plans by offering and/or receiving things of value because of, or with intent to influence, the advice Marsh gave to its clients. The Marsh Enterprise Defendants likewise conspired to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d).

Based on Marsh's relationship with its clients, its fiduciary duty and its representations, Marsh had a duty to fully disclose any conflicts of interest it had in providing services to its clients as well as any material information that might impact its ability to act in its client's best interest. Instead, the Marsh Enterprise Defendants engaged in a scheme whereby the Marsh Enterprise Defendants engaged in steering and other practices in order to maximize the volume of insurance placed with the Insurer Defendants and maximizing the volume of renewal business placed with the Insurer Defendants. In furtherance of the scheme, the Marsh Enterprise Defendants knowingly and intentionally concealed the following material matters from Marsh's clients who paid for the kickbacks through higher premiums:

- that Marsh was not acting in the best interest of its clients but was instead acting on behalf of the Marsh Enterprise Insurer Defendants and in furtherance of its own financial interests;
- the true nature of the association and agreements between Marsh and the Marsh Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between Marsh and the Marsh Enterprise Insurer Defendants;
- Marsh’s consolidation of its insurance markets to a few select strategic partners;

- Marsh's steering of insurance placements to the Marsh Enterprise Insurer Defendants;
- that Marsh was protecting the Marsh Enterprise Insurer Defendants from competition;
- that the Marsh Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Marsh in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that Form 5500 documents did not accurately reflect the fees and commissions paid from the Marsh Enterprise Insurer Defendants to Marsh
- that the Marsh Enterprise Insurer Defendants factor the kickbacks paid to Marsh into the cost of Plaintiffs' and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

The Marsh Enterprise Defendants' fraudulent scheme violated 18 U.S.C. 1962(c) and (d).

In addition, as set forth in response to Question 14, Marsh violated 18 U.S.C. 1962(d) by conspiring with Aon, Gallagher, Willis, USI and ULR to prevent detection of each broker's fraudulent scheme.

The Aon Enterprise Defendants:

Aon[9] and CIGNA , Hartford , MetLife , Prudential and UnumProvident (collectively the "Aon Enterprise Defendants") formed an association in fact enterprise (the Aon enterprise) and participated in or conducted the affairs of the Aon enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c), utilizing interstate mail and wire in furtherance of the scheme, as well as undertaking the unlawful influence of ERISA governed plans by offering

[9] "Aon" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

and/or receiving things of value because of, or with intent to influence, the advice Aon gave to its clients. The Aon Enterprise Defendants likewise conspired to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d).

Based on Aon's relationship with its clients, its fiduciary duty and its representations, Aon had a duty to fully disclose any conflicts of interest it had in providing services to its clients as well as any material information that might impact its ability to act in its client's best interest. Instead, the Aon Enterprise Defendants engaged in a scheme whereby the Aon Enterprise Defendants engaged in steering and other practices in order to maximize the volume of insurance placed with the Insurer Defendants and maximizing the volume of renewal business placed with the Insurer Defendants. In furtherance of the scheme, the Aon Enterprise Defendants knowingly and intentionally concealed the following material matters from Aon's clients who paid for the kickbacks through higher premiums:

- that Aon was not acting in the best interest of its clients but was instead acting on behalf of the Aon Enterprise Insurer Defendants and in furtherance of its own financial interests;
- the true nature of the association and agreements between Aon and the Aon Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between Aon and the Aon Enterprise Insurer Defendants;
- Aon's consolidation of its insurance markets to a few select strategic partners;
- Aon's steering of insurance placements to the Aon Enterprise Insurer Defendants;
- that Aon was protecting the Aon Enterprise Insurer Defendants from competition;

- that the Aon Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Aon in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function because of, or with intent to influence, the advice Aon gives its clients;
- that Form 5500 documents did not accurately reflect the fees and commissions paid from the Aon Enterprise Insurer Defendants to Aon;
- that the Aon Enterprise Insurer Defendants factor the kickbacks paid to Aon into the cost of Plaintiffs' and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

Aon and the Aon Enterprise Insurer Defendants' fraudulent scheme violated 18 U.S.C. 1962(c) and (d).

In addition, as set forth in response to Question 14, Aon violated 18 U.S.C. 1962(d) by conspiring with Marsh, Gallagher, Willis, USI and ULR to prevent detection of each broker's fraudulent scheme.

The ULR Enterprise Defendants

ULR[10] and CIGNA, Hartford, MetLife, Prudential and Unum (collectively the "ULR Enterprise Defendants") formed an association in fact enterprise (the ULR enterprise) and participated in or conducted the affairs of the ULR enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c), utilizing interstate mail and wire in furtherance of the scheme, as well as undertaking the unlawful influence of ERISA governed plans by offering

[10] "ULR" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

and/or receiving things of value because of, or with intent to influence, the advice ULR gave to its clients. ULR and INSURERS likewise conspired to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d).

Based on ULR's relationship with its clients, its fiduciary duty and its representations, ULR had a duty to fully disclose any conflicts of interest it had in providing services to its clients as well as any material information that might impact its ability to act in its client's best interest. Instead, the ULR Enterprise Defendants engaged in a scheme whereby the ULR Enterprise Defendants engaged in steering and other practices in order to maximize the volume of insurance placed with the Insurer Defendants and maximizing the volume of renewal business placed with the Insurer Defendants. In furtherance of the scheme, the ULR Enterprise Defendants knowingly and intentionally concealed the following material matters from ULR's clients who paid for the kickbacks through higher premiums:

- that ULR was not acting in the best interest of its clients but was instead acting on behalf of the ULR Enterprise Insurer Defendants and in furtherance of its own financial interests;
- the true nature of the association and agreements between ULR and the ULR Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between ULR and the ULR Enterprise Insurer Defendants;
- ULR's consolidation of its insurance markets to a few select strategic partners;
- ULR's steering of insurance placements to the ULR Enterprise Insurer Defendants;
- that ULR was protecting the ULR Enterprise Insurer Defendants from competition;

- that the ULR Enterprise Insurer Defendants kick back a substantial portion of their increased profits to ULR in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that Form 5500 documents did not accurately reflect the fees and commissions paid from the ULR Enterprise Insurer Defendants to ULR;
- that the ULR Enterprise Insurer Defendants factor the kickbacks paid to ULR into the cost of Plaintiffs' and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

The ULR Enterprise Defendants' fraudulent scheme violated 18 U.S.C. 1962(c) and (d).

In addition, as set forth in response to Question 14, ULR violated 18 U.S.C. 1962(d) by conspiring with Marsh, Aon, Willis, USI and Gallagher to prevent detection of each broker's fraudulent scheme.

Gallagher and INSURERS

Gallagher[11] and AIG, CIGNA, Hartford, MetLife, Prudential and Unum (collectively the "Gallagher Enterprise Defendants") formed an association in fact enterprise (the Gallagher enterprise) and participated in or conducted the affairs of the Gallagher enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c), utilizing interstate mail and wire in furtherance of the scheme, as well as undertaking the unlawful influence of ERISA governed plans by offering and/or receiving things of value because of, or with intent to

[11] "Gallagher" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

influence, the advice Gallagher gave to its clients. Gallagher and INSURERS likewise conspired to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d).

Based on Gallagher's relationship with its clients, its fiduciary duty and its representations, Gallagher had a duty to fully disclose any conflicts of interest it had in providing services to its clients as well as any material information that might impact its ability to act in its client's best interest. Instead, the Gallagher Enterprise Defendants engaged in a scheme whereby the Gallagher Enterprise Defendants engaged in steering and other practices in order to maximize the volume of insurance placed with the Insurer Defendants and maximizing the volume of renewal business placed with the Insurer Defendants. In furtherance of the scheme, the Gallagher Enterprise Defendants knowingly and intentionally concealed the following material matters from Gallagher's clients who paid for the kickbacks through higher premiums:

- that Gallagher was not acting in the best interest of its clients but was instead acting on behalf of the Gallagher Enterprise Insurer Defendants and in furtherance of its own financial interests;
- the true nature of the association and agreements between Gallagher and the Gallagher Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between Gallagher and the Gallagher Enterprise Insurer Defendants;
- Gallagher’s consolidation of its insurance markets to a few select strategic partners;
- Gallagher’s steering of insurance placements to the Gallagher Enterprise Insurer Defendants;

- that Gallagher was protecting the Gallagher Enterprise Insurer Defendants from competition;
- that the Gallagher Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Gallagher in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that Form 5500 documents did not accurately reflect to the fees and commissions paid from the Gallagher Enterprise Insurer Defendants to Gallagher;
- that the Gallagher Enterprise Insurer Defendants factor the kickbacks paid to Gallagher into the cost of Plaintiffs' and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

Gallagher and the Gallagher Enterprise Insurer Defendants' fraudulent scheme violated 18 U.S.C. 1962(c) and (d).

In addition, as set forth in response to Question 14, Gallagher violated 18 U.S.C. 1962(d) by conspiring with Marsh, Aon, Willis, USI, and ULR to prevent detection of each broker's fraudulent scheme.

Willis Enterprise Defendants

Willis[12] and CIGNA, Hartford, MetLife, Prudential and Unum ("collectively the Willis Enterprise Defendants") formed an association in fact enterprise (the Willis enterprise) and participated in or conducted the affairs of the Willis enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c), utilizing interstate mail and wire in furtherance of

[12] "Willis" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

the scheme, as well as undertaking unlawful influence of ERISA governed plans by offering and/or receiving things of value because of, or with intent to influence, the advice Willis gave to its clients. Willis and the Willis Enterprise Insurer Defendants likewise conspired to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d).

Based on Willis' relationship with its clients, its fiduciary duty and its representations, Willis had a duty to fully disclose any conflicts of interest it had in providing services to its clients as well as any material information that might impact its ability to act in its client's best interest. Instead, the Willis Enterprise Defendants engaged in a scheme whereby the Willis Enterprise Defendants engaged in steering and other practices in order to maximize the volume of insurance placed with the Insurer Defendants and maximizing the volume of renewal business placed with the Insurer Defendants. In furtherance of the scheme, the Willis Enterprise Defendants knowingly and intentionally concealed the following material matters from Willis's clients who paid for the kickbacks through higher premiums:

- that Willis was not acting in the best interest of its clients but was instead acting on behalf of the Willis Enterprise Insurer Defendants and in furtherance of its own financial interests;
- the true nature of the association and agreements between Willis and the Willis Enterprise Insurer Defendants
- the conflict of interest inherent in the agreements between Willis and the Willis Enterprise Insurer Defendants;
- Willis’s consolidation of its insurance markets to a few select strategic partners;
- Willis’s steering of insurance placements to the Willis Enterprise Insurer Defendants;
- that Willis was protecting the Willis Enterprise Insurer Defendants from competition;

- that the Willis Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Willis in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that Form 5500 documents did not accurately reflect the fees and commissions paid from the Willis Enterprise Insurer Defendants to Willis;
- that the Willis Enterprise Insurer Defendants factor the kickbacks paid to Willis into the cost of Plaintiffs' and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

The Willis Enterprise Defendants' fraudulent scheme violated 18 U.S.C. 1962(c) and (d).

In addition, as set forth in response to Question 14, Willis violated 18 U.S.C. 1962(d) by conspiring with Marsh, Aon, Gallagher, USI, and ULR to prevent detection of each broker's fraudulent scheme.

USI

As set forth in response to Question 14, USI[13] violated 18 U.S.C. 1962(d) by conspiring with Marsh, Aon, Willis, Gallagher and ULR to prevent detection of each broker's fraudulent scheme. Plaintiffs do not allege a USI Centered Enterprise. However, as discussed more fully in the Second Amended Complaint and Revised Particularized Statement, USI undertook the same conduct as the other Broker Defendants.

Insurer Defendants

[13] "USI" collectively refers to the Defendants identified in the Second Consolidated Amended Employee Benefits Class Action Complaint.

In addition to the Insured Defendant's liability as set forth above, and in response to Question 14, all of the Employee Benefits Insurer Defendants also violated 18 U.S.C. 1962(d) by conspiring with one another to prevent detection of each broker's fraudulent scheme.

3. List the alleged wrongdoers, other than the defendants listed above, and state the alleged misconduct of each wrongdoer.

Persons who participated in the same type of wrongdoing alleged herein in the commercial insurance market include Karen Radke, Jean-Baptiste Tateossian, Carlos Coello and James Mohs of AIG; Patricia Abrams of ACE; John Keenan, Edward Coughlin and James Spiegel of Zurich American Insurance Company; Kevin Bott of Liberty Mutual and Robert Stearns, Joshua Bewlay, Kathryn Winter, Regina Hatton, Nicole Michaels, Jason Monteforte, Todd Murphy, Peter Andersen, and Mark Manzi of Marsh. These individuals have pleaded guilty to criminal charges for their involvement in a bid-rigging scheme. The following persons have also been the subject of criminal investigations which led to indictments: Greg Doherty, Kathleen Drake, William Gilman, Thomas T. Green, Edward Keane Jr., William McBurnie, Edward McNenny, and Joseph Peiser.

4. List the alleged victims and state how each victim was allegedly injured.

Plaintiffs and Class Members are victims of Defendants' pattern of racketeering activity and conspiracies. Each Plaintiff and Class Member was injured because Defendants' illegally increased profits were imbedded in the insurance premiums paid by or on behalf of Plaintiffs and Class Members; accordingly, Defendants' control of the enterprise through the pattern of racketeering and their conspiracy regarding the fraudulent scheme and concealment of the scheme proximately caused the cost of insurance obtained by all Plaintiffs and Class Members to increase, thereby injuring them in their business and property.

5. Describe in detail the pattern of racketeering activity or collection of unlawful debts alleged for each RICO claim. A description of the pattern of racketeering shall include the following information:

a. List the alleged predicate acts and the specific statutes which are allegedly violated;

In carrying out their scheme, Defendants have violated 18 U.S.C. § 1954 barring the payment of monies other thing of value because of, or intended to influence, the advice the Defendant Brokers gave to the plan sponsors, plan administrators and/or plan. Defendants have engaged in numerous predicate acts of mail and wire fraud. In carrying out these overt acts and fraudulent schemes described throughout this Amended RICO Case Statement, defendants have violated federal laws including mail and wire fraud, 18 U.S.C. §§ 1341 and 1343. These predicate acts constitute a pattern of racketeering through which defendants have violated 18 U.S.C. 1962(c) and (d).

b./c. Provide the dates of the predicate acts, the participants in the predicate acts, and a description of the facts surrounding the predicate acts; If the RICO claim is based on the predicate offenses of wire fraud, mail fraud, or fraud in the sale of securities, provide the "circumstances constituting fraud or mistake [which] shall be stated with particularity." Fed. R. Civ. P. 9(b). Identify the time, place and contents of the alleged misrepresentations, and the identity of persons to whom and by whom the alleged misrepresentations were made;

The participants in the predicate acts include all the EB Insurer defendants and EB Broker Defendants as set forth in Section 2. The facts and circumstances surrounding the predicate acts evidence (1) a fraudulent scheme and (2) unlawful payments to Brokers which were made and/or accepted because of the Brokers relationship to the ERISA plans and/or with the intent to influence the advice Brokers provided to ERISA plans, the plan sponsors, plan administrator and/or plan participants.

The object of the fraudulent scheme has been to increase the insurers' premium revenues by the Broker Defendants' allocation of business to the insurers in return for kickbacks which

increase the Broker Defendants' revenues beyond what clients would otherwise be willing to pay for such services. Likewise, the object of the unlawful payments and their concealment was to increase Defendants revenue. Therefore, the kickbacks were undisclosed by the Defendants and were passed on to Plaintiffs and Class Members without the latter's knowledge.

Violations of 18 U.S.C. § 1954 (Unlawful Influence)

Defendants have violated 18 U.S.C. § 1954 ("Section 1954") with each payment or receipt of a contingent commission and/or other thing of value because such payments were because of, or intended to influence, the advice the Defendant Brokers gave to the plan sponsors, plan administrators and/or plan participants. The Defendants entered strategic partnership agreements (which included payment of contingent commissions and/or other things value) with the intent, or because of, increasing the Broker's compensation and the premiums written by the Defendant Insurers.

Both the Broker Defendants and the Insurer Defendants violated Section 1954 through their participation in the scheme described herein. Such a scheme violates Section 1954 because the payment of commissions and/or other thing of value was given and received with the intent of influencing the advice that Defendant Brokers provided to ERISA plans, plan sponsors (employers), plan administrators and/or plan participants. The scheme was designed to steer business and fundamentally compromised the advice Brokers gave to parties having an interest in the ERISA plans. The Insurer Defendants' payment of contingent commission and/or other things of value and Broker Defendants' acceptance of such payment, because of, or intended to influence, the advice the Defendant Brokers gave to the plan sponsors, plan administrators and/or plan participants.

Despite this, neither the Broker Defendants nor the Insurer Defendants disclosed the payments offered and accepted, the inherent conflict of interest, or any other portion of the scheme despite an obligation to do so. Indeed, since 1986 the United States Department of Labor has consistently required disclosure of contingent commissions on the Schedule A Form 5500's. This disclosure requirement imposed a corresponding duty on the Insurer Defendants to furnish accurate information to the plan administrators about all commissions and fees paid to the plan's broker. The Insurer Defendants discussed and/or obtained information about what other Insurer Defendants were doing with respect to paying and disclosing contingent commissions and agreed not to disclose or to mislead about these kickbacks on Form 5500 documents and certifications. Likewise, Broker Defendants conspired with one another in furtherance of the scheme to violate Section 1954 by agreeing not to disclose the kickbacks because of, or with intent to influence, the advice given the Broker Defendants. The ERISA class members were injured as a result of these kickbacks.

Examples of Mail and Wire Fraud Predicate Acts

The alleged predicate acts occur on a regular and on-going basis. The following are some examples of predicate acts. Specific details regarding more precise dates, times, places and identities of other parties participating in many of the predicate acts will be provided after further investigation and discovery.

Marsh Enterprise Defendants

The Marsh Enterprise Defendants have violated 18 U.S.C. § 1341 and 18 U.S.C. § 1343 by utilizing or causing the use of the United States postal service, commercial interstate carrier, wire or other interstate electronic media in furtherance of their fraudulent scheme.

Defendants have engaged in a scheme whereby Marsh would allocate business to a limited number of partner Insurer Defendants in exchange for kickbacks in the form of contingent commissions and/or other payments which were factored into the premiums paid by plaintiffs and class members. Specifically, as set forth in further detail in the Particularized Statement and the Complaint, Marsh in conjunction with the Marsh Enterprise Insurer Defendants engaged in the following conduct:

- Marsh significantly consolidated the number of carriers to which it would market its clients' business.
- Marsh entered into "strategic partnerships" with the Marsh Enterprise Insurer Defendants to which Marsh agreed to steer the bulk of its business.
- As strategic partners, the Marsh Enterprise Insurer Defendants would be given access to a guaranteed flow of premium volume from Marsh, as well as protection from normal competition from both inside and outside of the strategic partnership for renewal of each Insurer Defendant's own business.
- In order to accomplish this, Marsh and the Marsh Enterprise Insurer Defendants engaged in a number of practices specifically set forth in the Revised Particularized Statements including agreements not to bid renewals competitively, limiting the marketing of renewals, and other actions designed to maximize the volume of insurance placed with the Marsh Enterprise Insurer Defendants.
- Marsh and Marsh Enterprise Insurer Defendants provided materially misleading Form 5500 certifications and documents to plan administrators.
- In exchange for being given these unfair competitive advantages, the Marsh Enterprise Insurer Defendants agreed to pay kickbacks to Marsh.

In furtherance of the scheme, Marsh and the Marsh Enterprise Insurer Defendants have sent matters and things through the mail and wire or have known that mail or wire would be used in furtherance of the scheme. Materials sent by mail or wire have included correspondence, emails, faxes, marketing materials, contracts or agreements between Marsh and the client, requests for proposals, policies and policy materials, insurance quotes, Form 5500 Schedule A documents and certifications, contingent commission agreements, insurance binders, commission schedules, invoices to clients and payments from insurers to brokers.

Mercer, in its Benefits Outsource Contract with HISD requires certain disclosures Defendants simply ignored. Specifically, the contract states:

> **CONFLICTS OF INTEREST.** Consultant agrees to provide 30 days prior written notice to Client detailing any arrangement or agreement between Consultant and any 3rd party currently existing, where the arrangement or agreement is related to the Services provided under this Agreement and where such relationship creates or reasonably could be anticipated to create an opportunity for Consultant to benefit financially or in any other material manner from Client's contract with the 3rd party.
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> * * *
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> **DISCLOSURE.** Consultant acknowledges that it must immediately disclose, upon discovery by Consultant, any agreement between it and any third party whereby consideration appears to be wholly or partly for any commission, fees, awards, prizes, trips or travel, finder's fees, placement fees, gifts, cross-consulting agreement, or any other inducement for services ("Gifts"), which have been given as a result of entering into this agreement. Consultant acknowledges that final determination of its violation of this section resides in the sole and reasonable discretion of Client. Consultant further acknowledges and agrees that violation of this section as determined by Client provides Client, at Client's option, with the remedy of (I) a refund by Consultant to Client, the refund consisting of the value of the Gift, such value to be reasonably determined solely by Client; or (ii) termination of this Agreement For Cause under section 3.2 at Client's sole option. Consultant further acknowledges its duty to confirm in writing to Client its compliance with this section 19, from time to time, upon request by Client.

In general, when responding to client questions, Marsh employees are instructed to state: "Our guiding principle is to consider our client's best interest in all placements. We are our clients' advocates and we represent them in negotiations. We don't represent the [insurers]."

In a proposal sent by Marsh Advantage America to Plaintiff Fire District of Sun City West on or about April 30, 2001, Marsh includes the following explanation regarding compensation:

> Marsh Advantage America and its affiliated companies, ("Marsh") may have agreements with insurers providing the insurance coverage which is placed by Marsh pursuant to which Marsh may derive compensation contingent upon such factors as the size, growth and/or profit ability of total business placed by Marsh with such insurers. Such contingent compensation is considered an industry standard and would be in addition to any other compensation Marsh may receive such as retail and wholesale brokerage fees or commissions, administrative fees, etc.

This proposal was insufficient to fully disclose Marsh's compensation arrangements with the Marsh Enterprise Insurer Defendants failing to provide any information regarding the strategic partnerships that Marsh had entered into with the Marsh Enterprise Insurer Defendants or the significance these partnerships and the contingent payment arrangements had on the insurance placement process and the premiums charged.

Marsh and the Marsh Enterprise Insurer Defendants have frequently communicated with each other by mail and/or wire in furtherance of the scheme. Such communications have included contingent commission agreements, letters, faxes and emails memorializing various agreements between Marsh and its partner markets and details regarding consolidation, requests for bids and bids, invoices, and contingent payments. Many instances of these types of communications are further detailed in the Revised Employee Benefits Particularized Statement and the Second Amended Employee Benefits Complaint.

Defendants' scheme is at odds with Marsh's duties and misrepresentations to clients. Marsh is retained by its clients, including Plaintiffs and Class Members, for the sole purpose of acting on behalf of and providing the clients with unbiased advice concerning the type, amount and level of insurance needed, as well as to provide sound and accurate advice regarding the insurance companies they recommend.

Additionally, Marsh is a fiduciary of its clients, and therefore owes its clients, including Plaintiffs and other members of the Class: (i) a duty of loyalty to act in the best interests of its clients and to always put its clients' interests ahead of its own; (ii) a duty of full and fair disclosure and complete candor in connection with any insurance-related products purchased by clients or services rendered by Marsh, including the duty to disclose the source and amounts of all income it receives in or as a result of any transaction involving its clients; (iii) a duty of care in connection with any insurance-related products purchased by its clients or services rendered by Marsh; (iv) a duty to provide impartial advice in connection with any insurance-related products purchased by its clients or services rendered by Marsh; (v) a duty to use its best business judgment in connection with any insurance-related products or services purchased by their clients – in other words to find the best coverage at the lowest price; and, (vi) a duty of good faith and fair dealing.

In his 1998 speech to RIMS, Roger Egan recognized that Marsh has "a duty to fully disclose [its] income." In a document created to assist employees in responding to client questions regarding regulatory investigations, Marsh wrote: "Our guiding principle is to consider our client's best interest in all placements. We are our clients' advocates and we represent them in negotiations. We don't represent the markets." Since the announcement of the investigation by Attorney General Spitzer, Marsh has yet again acknowledged and affirmed its duty to act on

behalf of its clients. In a October 29, 2004 letter to "the Clients of Marsh" from Michael G. Cherkasky, Chairman and Chief Executive Officer of Marsh Inc., Cherkasky stated, "We must reaffirm our commitment to you and provide you with complete assurance that we will execute transactions in your best interest and in accordance with the highest professional and ethical standards." Marsh then reaffirmed, "There are more than 42,000 colleagues at Marsh who believe – as they always have – that the clients' interests must come first."

As a result of the nature of the relationship between Marsh and its clients, as a result of Marsh's fiduciary status and as a result of Marsh's representations, Marsh had a duty to fully disclose any conflicts of interest it had in providing services to their clients as well as any material information that might impact their ability to act in its client's best interest. Marsh, however, did not disclose its conflicts of interest, its allocation of business to a limited number of insurer partners or the resulting harm to its clients.

Marsh's communications with its clients, including Plaintiffs, which contained material misrepresentations and/or omissions are evidenced by the examples set forth herein. Throughout the Class Period, Marsh regularly disseminated materials by mail and wire to its clients. To the extent Marsh provided any information regarding contingent commission income or Marsh's relationship with Marsh Enterprise Insurer Defendants the information was either materially false or misleading. For example, in an agreement with Plaintiff's Kimball's employer, Houston Independent School District, Mercer represented that it would:

- "Analyze and review service provider proposals"
- "Score proposal responses"
- "Prepare report and recommendations of service provider finalist"
- "Select vendor finalist"

- "Service provider finalist interviews"
- "Service provider contract agreement review"
- "Negotiate with vendors based on RFP results"
- "Present recommendations of winners/losers"
- "Finalize vendor contract agreement"
- "Act on behalf Client and/or Client employees as an advocate for company-sponsored benefit-related disputes with health plans and contracted vendors and providers".

On or about July 2, 1998, Sedgwick James of Arizona, Inc. ("Sedgwick James"), which was purchased by Marsh in 2000, sent the Fire District of Sun City West (the "Fire District") a brokerage services agreement. The brokerage services agreement provides as follows:

> Sedgwick James of Arizona, Inc. d/b/a/ Sedgwick Noble Lowndes is pleased to accept an appointment with Fire District of Sun City West as your employee benefits consultant for your Group Life, Accidental Death & Disbursement, Dental, Medical, Long Term Disability and 401(k) insurance programs. Our consulting agreement begins on July 1, 1994 and will continue until canceled by either of us provided written notice is received at least (30) days in advance. Fire District of Sun City West has agreed to have the following insurance companies pay Sedgwick Noble Lowndes commission.
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> |---|---|---|
> | Blue Cross/Blue Shield | Medical | 6% |
> | Blue Cross/Blue Shield | Dental | 10% |
> | MetLife | Life | 15% |
> | Standard | LTD | 15% |
>
> For the above stated commission, Sedgwick Noble Lowndes agrees to provide the following services for Fire District of Sun City West: Review of Benefit Objectives, Renewal Service, Marketing Service, and Claims, Premium and Billing Assistance. The cost for additional services desired by Fire District of Sun City West shall be separately negotiated.
>
> Sedgwick Noble Lowndes will review the services being provided and the associated costs as needed. ***It is Sedgwick Noble Lowndes' intent to continue serving Fire District of Sun City West in a professional manner and to provide the expertise that Fire District of Sun City West requires to maintain a cost-effective and competitive employee benefit program.***

On or about July 17, 1996, Sedgwick James sent the Fire District a similar agreement that provided the same representations as above. These agreements contained no reference to contingent commissions, and thus failed to adequately disclose the compensation arrangements Marsh had with the Marsh Enterprise Insurer Defendants for the payment of contingent commissions. Moreover, these agreements failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that Marsh may have in advising its clients and constitutes a breach of Marsh's fiduciary duties. These agreements also failed to disclose that Marsh was allocating business to the Marsh Enterprise Insurer Defendants who have agreed to pay contingent commissions.

Marsh made similar misrepresentations and omissions to Plaintiffs in other documents it sent to its clients. On February 23, 1999, Marsh transmitted to Connecticut Spring and Stamp ("CT Spring") a memorandum outlining a February 2, 1999 meeting. Within this document, Marsh states objectives to be met, including that Marsh would "consider carriers that have the ability to provide coverage locally, regionally and nationally." Additionally, Marsh stated it would "provide a cost to CT Spring (as employer) that is very competitive." In addition, the memo outlines several different carriers stating "[w]e work with all the above carriers" and "[i]n competitive bidding, we have seen quotes from all the above carriers." Marsh's subsidiary, Seabury & Smith, Inc. ("Seabury & Smith") sent a letter to plaintiff Waxman on or about December 16, 1999, offering her the opportunity to purchase Group Universal Life insurance underwritten by Metropolitan Life Insurance Company. This letter stated that the coverage was offered at "favorable group rates." After plaintiff Waxman purchased this coverage, on or about January 23, 2000, Seabury & Smith sent plaintiff Waxman another letter enclosing a Certificate Specifications page describing the coverage purchased and stating that plaintiff Waxman would

now "have access to low-cost protection." These materials failed to adequately disclose the compensation arrangements Marsh had with the Marsh Enterprise Insurer Defendants for the payment of contingent commissions. Moreover, these materials failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that Marsh may have in advising its clients and constitutes a breach of Marsh's fiduciary duties. These materials also failed to disclose that Marsh was allocating business to the Marsh Enterprise Insurer Defendants who have agreed to pay contingent commissions.

In a letter dated January 29, 1999 from William M. Mercer, Inc. ("Mercer") to plaintiff Golden Gate Bridge, Highway and Transportation District ("Golden Gate"), Mercer stated the following:

> We received the following commissions and directed fees shown below for the value of services rendered in connection with your welfare benefit plans during the fourth quarter of 1998.
>
> | Commissions and Directed Fees * | Time and Expense |
> |---|---|
> | $23,368 | $22,864 |
>
> * This includes the $2,700 monthly retainer paid by the District
>
> Part or all of our fees have been paid in the form of commissions we received. Commissions may constitute plan assets, in which using commissions to pay our fees is a fiduciary responsibility under ERISA. We strongly recommend that your legal counsel review the Department of Labor's guidance on the use of plan assets to pay expenses and determine if it is appropriate to use commission revenue or other plan assets to pay the fees shown.

This letter failed to adequately disclose the compensation arrangements Mercer/ Marsh had with Marsh Enterprise Insurer Defendants for the payment of contingent commissions. Moreover, this letter failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that Mercer/Marsh may have in advising its clients and constitutes a breach of Mercer/Marsh's fiduciary duties. This letter also failed to disclose that Mercer/Marsh was

allocating business to Marsh Enterprise Insurer Defendants who have agreed to pay contingent commissions.

Mercer's invoice to Golden Gate dated March 20, 2003 (for services rendered between April and August of 2002), also contained the following language:

> Part or all of our fees have been paid in the form of commissions we received. Commissions may constitute ERISA plan assets, in which case the use of commissions to pay our fees is a fiduciary responsibility under ERISA. The application of commissions to pay certain fees in this invoice should not be interpreted as our advice or recommendation that the fees can or should be paid from plan assets. We recommend that you review the Department of Labor's guidance on the use of plan assets to pay expenses and that you seek legal counsel where appropriate.

This invoice failed to adequately disclose the compensation arrangements Mercer had with the Marsh Enterprise Insurer Defendants for the payment of contingent commissions. Moreover, this invoice failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that Mercer may have in advising its clients and constitutes a breach of Mercer's fiduciary duties. This invoice also failed to disclose that Mercer was allocating business to Marsh Enterprise Insurer Defendants who have agreed to pay contingent commissions.

Marsh also sent invoices to its clients which included the excess premiums resulting from Defendants' scheme without a separate accounting of the excess amount being invoiced. In the invoices forwarded to clients, Marsh noted only that it "may have" agreements with insurers "pursuant to which Marsh may derive compensation contingent upon such factors as the size, growth and/or overall profitability of total business placed by Marsh with such insurers." This statement was insufficient to fully disclose Marsh's compensation arrangements with Marsh Enterprise Insurer Defendants, noting only that Marsh "may have" agreements with insurers from which Marsh "may" derive additional income while failing to provide any information regarding the strategic partnerships that Marsh had entered into with the Marsh Enterprise

Insurer Defendants or the significance these partnerships and the contingent payment arrangements had on the insurance placement process and the premiums charged. Marsh sent such invoices to Fire District on July 1, 1994, July 18, 1994, October 5, 1994, June 29, 2000, June 30, 2000, July 11, 2000, July 25, 2000, July 24, 2001, July 15, 2002, August 1, 2002, September 3, 2002, November 1, 2002, December 1, 2002, December 2, 2002, January 13, 2003, January 31, 2003, February 1, 2003, February 24, 2003, March 3, 2003, June 25, 2003, July 18, 2003, July 25, 2003, August 22, 2003, August 25, 2003, September 2, 2003, September 25, 2003, October 1, 2003, October 24, 2003, November 3, 2003, December 1, 2003, December 2, 2003, March 2, 2004, June 25, 2004, July 23, 2004, July 31, 2004, and August 3, 2004.

Marsh also sent annual letters to Golden Gate regarding renewal of Golden Gate's employee benefit plan insurance, such as those transmitted on June 4, 1998, June 5, 2000, June 2001, and June 5, 2002. Mercer/Marsh also transmitted to Golden Gate annual summaries of employee benefit plan insurance, such as those transmitted in September 1994, September 1995, October 1996, September 1997, July 1998, October 1999, and October 2000. Mercer/Marsh also sent numerous invoices for services and related cover-letters to Golden Gate. Exemplars of such invoices are dated June 30, 1998; July 31, 1998; September 10, 1998; October 13, 1998; November 11, 1998; December 11, 1998; January 13, 1999; February 9, 1999; April 12, 1999; April 30, 1999; June 9, 1999; August 11, 2000; September 14, 2000; August 9, 2001; April 15, 2002; June 1, 2002; June 6, 2002; and July 15, 2002. These letters, summaries and invoices also failed to adequately disclose the compensation arrangements Marsh had with various Insurer Defendants for the payment of contingent commissions. Moreover, these materials failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that Marsh may have in advising its clients and constitutes a breach of Marsh's duties. These

materials also failed to disclose that Marsh was allocating business to Insurer Defendants who have agreed to pay contingent commissions.

During the relevant time period, Marsh also caused insurance policies and various other communications related to those policies to be transmitted to plaintiffs Boros, Kimball, Waxman, CT Spring, Fire District and Golden Gate, including information transmitted through the Internet. These materials failed to adequately disclose the compensation arrangements that Marsh had with the Marsh Enterprise Insurer Defendants for the payment of contingent commissions. Moreover, these materials failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that Marsh may have in advising its clients and constitutes a breach of Marsh's duties. These materials also failed to disclose that Marsh was allocating business to the Marsh Enterprise Insurer Defendants who have agreed to pay contingent commissions.

Marsh did not disclose the following material facts in any of its communications with clients:

- that Marsh was not acting in the best interest of its clients but was instead acting on behalf of itself and its partner carriers to further their financial interests at the expense of Marsh's clients;
- the true nature of the association and agreements between Marsh and the Marsh Enterprise Insurer Defendants
- the conflict of interest inherent in the agreements between Marsh and the Marsh Enterprise Insurer Defendants;
- Marsh's consolidation of its insurance markets to a few select strategic partners;
- Marsh's steering of insurance placements to the Marsh Enterprise Insurer Defendants, its strategic partners;
- that the Marsh Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Marsh in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;

- that the kickbacks to Marsh are factored into the cost of Plaintiffs and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

Marsh's misrepresentation of its allegiance to its client's interests and concealment of Marsh's allocation of business to a limited number of the Marsh Enterprise Insurer Defendants was necessary to encourage clients to retain Marsh, to conceal the scheme, to lull clients, including Plaintiffs and Class Members, into a false sense of security and to assure payment of the excess premiums. Likewise, inclusion of the excess amount of premium resulting from Marsh and the Insurer Defendants' scheme in invoices forwarded to each Plaintiff without explanation or a separate accounting for the excess premium was necessary to conceal the scheme and to assure payment of the entire invoice amount.

The fraudulent scheme and the conspiracy in furtherance of the scheme proximately caused the cost of insurance obtained by Plaintiffs and Class Members to increase because the kickbacks paid to Marsh were included in the price of insurance paid by Plaintiffs and Class Members. In addition, Plaintiffs and Class Members reasonably relied on Marsh's representations and omissions in paying higher premiums that included the kickbacks to Marsh.

Despite Marsh's duties to its clients, despite Marsh's acknowledgement of its obligations and despite Marsh's representations, Marsh did not act in its clients' best interests but instead engaged in a fraudulent scheme designed to increase the profits of Marsh and its insurer partners at the expense of its clients.

ULR Enterprise Defendants

ULR and the ULR Enterprise Insurer Defendants have violated 18 U.S.C. § 1341 and 18 U.S.C. § 1343 by utilizing or causing the use of the United States postal service, commercial interstate carrier, wire or other interstate electronic media in furtherance of their fraudulent scheme.

Defendants have engaged in a scheme whereby ULR would allocate business to a limited number of partner Insurer Defendants in exchange for kickbacks in the form of contingent commissions and/or other payments which were factored into the premiums paid by plaintiffs and class members. Specifically, as set forth in further detail in the Revised Particularized Statement and the Second Amended Complaint, ULR in conjunction with the ULR Enterprise Insurer Defendants engaged in the following conduct:

- ULR significantly consolidated the number of carriers to which it would market its clients' business.
- ULR then entered into "strategic partnerships" with the ULR Enterprise Insurer Defendants to which ULR agreed to steer the bulk of its business.
- As strategic partners, the ULR Enterprise Insurer Defendants would be given access to a guaranteed flow of premium volume from ULR, as well as protection from normal competition from both inside and outside of the strategic partnership for renewal of each Insurer Defendant's own business.
- In order to accomplish this, ULR and the ULR Enterprise Insurer Defendants engaged in a number of practices specifically set forth in the Revised Particularized Statements including agreements not to bid renewals competitively, limiting the marketing of renewals and other actions designed to maximize the volume of insurance placed with the ULR Enterprise Insurer Defendants;
- ULR and the ULR Enterprise Insurer Defendants provided materially misleading Form 5500 certifications and documents to plan administrators;
- In exchange for being given these unfair competitive advantages, the ULR Enterprise Insurer Defendants agreed to pay kickbacks to ULR.

In furtherance of the scheme, ULR and the ULR Enterprise Insurer Defendants have sent matters and things through the mail and wire or have known that mail or wire would be used in furtherance of the scheme. Materials sent by mail or wire have included correspondence, emails, faxes, marketing materials, contracts or agreements between ULR and the client, requests for proposals, policies and policy materials, insurance quotes, Form 5500 Schedule A documents and certifications, contingent commission agreements, insurance binders, commission schedules, invoices to clients and payments from insurers to brokers.

ULR and ULR Enterprise Insurer Defendants have frequently communicated with each other by mail and/or wire in furtherance of the scheme. Such communications have included contingent commission agreements, letters, faxes and emails memorializing various agreements between Marsh and its partner markets and details regarding consolidation, requests for bids and bids, invoices, and contingent payments. Many instances of these types of communications are further detailed in the Revised Employee Benefits Particularized Statement and the Second Amended Employee Benefits Complaint.

For instance, ULR has taken steps to ensure that contingent commission information was not reported on Form 5500. For instance, ULR's bid for Dell's employee life insurance coverage claimed that is only compensation was a $120,000 payment from the insurance carrier that was ultimately selected. ULR indicated to UnumProvident that it would receive the Dell account, but UnumProvident represented to ULR that it could only submit the low bid if ULR waived the $120,000 RFP fee. ULR agreed but required UnumProvident to falsely report the commission on Dell's Schedule A Report because otherwise the failure to pay and report that commission would raise "red flags," because Dell had already authorized the payment. A UnumProvident employee explained:

> We removed the commissions so that we could get to the pricing of one of our competitors, ***but the client, probably not ware of broker override programs,*** would find it fishy if there were no commissions paid to ULR for the marketing. So we are ***making this arrangement so that we facilitate the [Schedule A] expectations from the client. We do not, however, wish to involve Dell in these discussion [sic] at all.***

As reflected in the form 5500 filed for Intel's Group Life and Accidental Death and Dismemberment Insurance Plan in 2001, UnumProvident told the plan it had paid [ULR] Cox $78,951 in commissions for the Group life, but ***nothing*** in fees; paid Cox $87,189 in commissions but ***no fees*** for the Group AD&D Plan; and paid Cox $5,500 in commissions but ***no fees*** for a Business Travel Accident Plan. In the Form 5500 for 2002, UnumProvident again only reported commissions, in the amount of $54,730, $86,731 and $5,500, respectively. In reality, ULR and Cox earned far more in undisclosed commissions, overrides and Communication Fees from UnumProvident. Intel (and its employees) paid $128 million for Group Life and Accidental Death and Dismemberment coverage in 2001 and a comparable amount in 2002. Unbeknownst to Intel and its employees, UnumProvident paid additional undisclosed overrides and Communication Fees in excess of ***$1,000,000*** to the ULR Defendants for 2001 and 2002.

Similarly, Prudential also cooperated with ULR's efforts to conceal payments received by ULR. For example, when asked by Prudential: "[T]he amount of commissions reported on the Report on Form 5500 is less than what was received in 2003. How would you like us to proceed?" ULR responded, "Just leave alone. Thanks." Moreover, Prudential knowingly provided a bid in February 2003 for Brinker International, Inc., after ULR expressly cautioned Prudential that "[c]ommunication fees . . . should not be communicated to the client without ULR's prior consent. Further, Prudential's top executives conspired to keep ULR's 2004 QBIA with Prudential "as confidential as possible." And, as recently as April 2004, Prudential engaged

in cooperative efforts with Aon to avoid reporting and to reclassify and restructure national payments "to avoid the appearance of conflict of interest and to make sure the revenue is properly booked to a nonrecurring revenue bucket (vs. commission revenue)."

In certain instances, some of the Defendants included clauses in their contingent commission agreements that would ensure this information would not be reported on Form 55000s. For example, the SPA between ULR and UnumProvident states: "Extra Compensation will not be reflected on ERISA Schedule A Reports" submitted to ULR's clients for filing with the IRS and DOL.

Defendants' scheme is at odds with ULR's duties and misrepresentations to clients. ULR is retained by its clients, including Plaintiffs and Class Members, for the sole purpose of acting on behalf of and providing the clients with unbiased advice concerning the type, amount and level of insurance needed, as well as to provide sound and accurate advice regarding the insurance companies they recommend.

Additionally, ULR is a fiduciary of its clients, and therefore owes its clients, including Plaintiffs and other members of the Class: (i) a duty of loyalty to act in the best interests of its clients and to always put its clients' interests ahead of its own; (ii) a duty of full and fair disclosure and complete candor in connection with any insurance-related products purchased by clients or services rendered by ULR, including the duty to disclose the source and amounts of all income it receives in or as a result of any transaction involving its clients; (iii) a duty of care in connection with any insurance-related products purchased by its clients or services rendered by ULR; (iv) a duty to provide impartial advice in connection with any insurance-related products purchased by its clients or services rendered by ULR; (v) a duty to use its best business judgment in connection with any insurance-related products or services purchased by their clients – in

other words to find the best coverage at the lowest price; and, (vi) a duty of good faith and fair dealing.

As a result of the nature of the relationship between ULR and its clients, as a result of ULR's fiduciary status and as a result of ULR's representations, ULR had a duty to fully disclose any conflicts of interest it had in providing services to their clients as well as any material information that might impact their ability to act in its client's best interest. ULR, however, did not disclose its conflicts of interest, its allocation of business to a limited number of insurer partners or the resulting harm to its clients.

ULR's communications with its clients, including Plaintiffs, which contained material misrepresentations and/or omissions are evidenced by the examples set forth herein.

For example, ULR represented to clients that its duties included the following:

- "[b]uild an RFP to support plan and pricing objectives";
- distribute it to all "qualified carriers";
- gather "all pertinent financial documents" from the insurers;
- interview responsible insurer personnel;
- review the insurers' pricing methodology;
- "evaluate all RFP responses";
- use "proprietary ULR tools to facilitate . . . selection";
- help the client select the carrier; and
- "negotiat[e] the final terms and conditions."

ULR's website likewise boasts that "[t]he services we offer are unique and highly specialized." It professes to objectively canvas a broad array of insurance companies for superior yet economical insurance coverage. And that it provides its "client and prospective

clients the 'best in class' consulting information." ULR's website also claims: "Our focus is to assist clients in the design, implementation and management of Group Life and Accident Insurance programs to achieve cost efficiencies and plan improvements."

To the extent ULR provided any information regarding contingent commission income or ULR's relationship with ULR Enterprise Insurer Defendants the information was either materially false or misleading. For example, during the relevant time period, ULR caused insurance policies and various other communications related to those policies to be transmitted to plaintiffs Brandes, including information transmitted through the Internet. Plaintiff Pombo also received during the relevant time period, marketing materials describing the Group Universal Life coverage offered by MetLife through her employer BP Corporation North America. These materials promised "competitive group rates." However, these materials failed to adequately disclose the compensation arrangements that ULR had with ULR Enterprise Insurer Defendants, for the payment of contingent commissions. Moreover, these materials failed to adequately disclose that the undisclosed compensation agreements destroy any objectivity that ULR may have in advising its clients and constitutes a breach of ULR's fiduciary duties. These materials also failed to disclose that ULR was allocating business to the ULR Enterprise Insurer Defendants who have agreed to pay contingent commissions.

ULR did not disclose the following material facts in any of its communications with clients:

- that ULR was not acting in the best interest of its clients but was instead acting on behalf of itself and its partner carriers to further their financial interests at the expense of ULR's clients;
- the true nature of the association and agreements between ULR and the ULR Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between ULR and the ULR Enterprise Insurer Defendants;

- ULR's consolidation of its insurance markets to a few select strategic partners;
- ULR's steering of insurance placements to the ULR Enterprise Insurer Defendants ULR Enterprise Insurer Defendants, its strategic partners;
- that ULR Enterprise Insurer Defendants kick back a substantial portion of their increased profits to ULR in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that the kickbacks to ULR are factored into the cost of Plaintiffs and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

ULR's misrepresentation of its allegiance to its client's interests and concealment of ULR's allocation of business to a limited number of partner Insurer Defendants was necessary to encourage clients to retain ULR, to conceal the scheme, to lull clients, including Plaintiffs and Class Members, into a false sense of security and to assure payment of the excess premiums. Likewise, inclusion of the excess amount of premium resulting from ULR and the Insurer Defendants' scheme in invoices forwarded to each Plaintiff without explanation or a separate accounting for the excess premium was necessary to conceal the scheme and to assure payment of the entire invoice amount.

The fraudulent scheme and the conspiracy in furtherance of the scheme proximately caused the cost of insurance obtained by Plaintiffs and Class Members to increase because the kickbacks paid to ULR were included in the price of insurance paid by Plaintiffs and Class Members. In addition, Plaintiffs and Class Members reasonably relied on ULR's representations and omissions in paying higher premiums that included the kickbacks to ULR.

Despite ULR's duties to its clients, despite ULR's acknowledgement of its obligations and despite ULR's representations, ULR did not act in its clients' best interests but instead engaged in a fraudulent scheme designed to increase the profits of ULR and its insurer partners at the expense of its clients.

Aon Enterprise Defendants

Aon and the Aon Enterprise Insurer Defendants have violated 18 U.S.C. § 1341 and 18 U.S.C. § 1343 by utilizing or causing the use of the United States postal service, commercial interstate carrier, wire or other interstate electronic media in furtherance of their fraudulent scheme.

Defendants have engaged in a scheme whereby AON would allocate business to a limited number of partner Insurer Defendants in exchange for kickbacks in the form of contingent commissions and/or other payments which were factored into the premiums paid by plaintiffs and class members. Specifically, as set forth in further detail in the Particularized Statement and the Complaint, AON in conjunction with Aon Enterprise Insurer Defendants engaged in the following conduct:

- AON significantly consolidated the number of carriers to which it would market its clients' business.
- AON then entered into "strategic partnerships" with the Aon Enterprise Insurer Defendants to which AON agreed to steer the bulk of its business.
- As strategic partners, the Aon Enterprise Insurer Defendants would be given access to a guaranteed flow of premium volume from AON, as well as protection from normal competition from both inside and outside of the strategic partnership for renewal of each Insurer Defendant's own business.
- In order to accomplish this, AON and the Aon Enterprise Insurer Defendants engaged in a number of practices specifically set forth in the Revised Particularized Statements including agreements not to bid renewals competitively, limiting the marketing of

renewals and other actions designed to maximize the volume of insurance placed with the Aon Enterprise Insurer Defendants.

- Aon and the Aon Enterprise Insurer Defendants provided materially misleading Form 5500 certifications and documents to plan administrators;
- In exchange for being given these unfair competitive advantages, the Aon Enterprise Insurer Defendants agreed to pay kickbacks to AON.

In furtherance of the scheme, Aon and the Aon Enterprise Insurer Defendants have sent matters and things through the mail and wire or have known that mail or wire would be used in furtherance of the scheme. Materials sent by mail or wire have included correspondence, emails, faxes, marketing materials, contracts or agreements between Aon and the client, requests for proposals, policies and policy materials, insurance quotes, Form 5500 Schedule A documents and certifications, contingent commission agreements, insurance binders, commission schedules, invoices to clients and payments from insurers to brokers.

Aon and the Aon Enterprise Insurer Defendants have frequently communicated with each other by mail and/or wire in furtherance of the scheme. Such communications have included contingent commission agreements, letters, faxes and emails memorializing various agreements between Marsh and its partner markets and details regarding consolidation, requests for bids and bids, invoices, and contingent payments. Many instances of these types of communications are further detailed in the Revised Employee Benefits Particularized Statement and the Second Amended Employee Benefits Complaint.

For example, while Aon knew that contingent commissions should be reported on Schedule A to the Form 5500, it stood by while carriers failed to do so and actively discouraged carriers from doing so as well. For example, Chuck Rysz, a Senior Vice President of Aon

Consulting, told a carrier [Mutual of Omaha] that proposed to report continent commissions that "[w]e may prefer if it were off 5500. Need to discuss further. For example, we would not want a 550[0] entry if you start paying us overrides on non-commission business" – something which Aon had demanded of the carrier because "other carriers do."

In an internal email dated July 23, 2003, Mark Holloway, an Aon ERISA attorney, acknowledged that "[t]he compliance friendly approach is to show the amount of the overrides on the Schedule A, although many carriers do not do so." In fact, in an internal email dated September 28, 2001, Aon stated that the revenue it earned on both national and regional contingent commissions is "not on the Schedule A forms," and acknowledged that "there was concern a couple of years ago regarding the impact of potential overrides and the fact this revenue was effectively not disclosed anywhere." Aon thought the industry could get away with it: "I am not aware of any DOL enforcement activity on this issue, at least so far."

Aetna, knowing that Aon was among "brokers [which] do not like to see large overrides reported on the 5500 forms we provide to their customers," assured Aon that it would take steps to make the amount of contingent commissions reported on each Schedule A appear smaller. Acknowledging that it built the cost of contingent commissions into its entire book of business, Aetna concluded that it could report overrides "in the manner in which we expense such commission, rather than the manner in which we calculate it," which would "enable us to spread the override reporting across a book of business." Anxious to remain in the good graces of its partner, Aon, Aetna forwarded its plans to make its reporting more broker-friendly to Bob Burden on August 14, 2002, saying, "Bob this is sensitive info so please do not share with anyone. Just wanted you to see where we are on some stuff[.]"

Similarly, another insurance company, in a letter to Aon, noted: "I've looked into the questions you raised relating to the terms of the override agreement. The override will not be represented on the Schedule A (based on present day standards)."

Defendants' scheme is at odds with Aon's duties and misrepresentations to clients. Aon is retained by its clients, including Plaintiffs and Class Members, for the sole purpose of acting on behalf of and providing the clients with unbiased advice concerning the type, amount and level of insurance needed, as well as to provide sound and accurate advice regarding the insurance companies they recommend.

Additionally, Aon is a fiduciary of its clients, and therefore owes its clients, including Plaintiffs and other members of the Class: (i) a duty of loyalty to act in the best interests of its clients and to always put its clients' interests ahead of its own; (ii) a duty of full and fair disclosure and complete candor in connection with any insurance-related products purchased by clients or services rendered by Aon, including the duty to disclose the source and amounts of all income it receives in or as a result of any transaction involving its clients; (iii) a duty of care in connection with any insurance-related products purchased by its clients or services rendered by Aon; (iv) a duty to provide impartial advice in connection with any insurance-related products purchased by its clients or services rendered by Aon; (v) a duty to use its best business judgment in connection with any insurance-related products or services purchased by their clients – in other words to find the best coverage at the lowest price; and, (vi) a duty of good faith and fair dealing.

As a result of the nature of the relationship between Aon and its clients, as a result of Aon's fiduciary status and as a result of Aon's representations, Aon had a duty to fully disclose any conflicts of interest it had in providing services to their clients as well as any material

information that might impact their ability to act in its client's best interest. Aon, however, did not disclose its conflicts of interest, its allocation of business to a limited number of insurer partners or the resulting harm to its clients.

Aon's communications with its clients, including Plaintiffs, which contained material misrepresentations and/or omissions are evidenced by the examples set forth herein. To the extent Aon provided any information regarding contingent commission income or Aon's relationship with Aon Enterprise Insurer Defendants the information was either materially false or misleading. For example, on or about December 6, 2001 Aon Consulting Inc. ("Aon") sent the City of Danbury a "letter of understanding." Among other things, the letter stated as follows:

> the associated fees are listed below:
> Comprehensive Annual Fee $61,500.00
> Project Based Fee $35,000.00
> (includes renewal negotiation, budget estimates and cost saving initiatives).

Attached to the December 6, 2001 letter from Aon was a document entitled "Danbury Proposal." The Danbury Proposal stated that Aon would "develop/analyze/provide results of RFP's as necessary to ensure highest quality/lowest cost coverage." On or about January 17, 2002 the City of Danbury and Aon entered into an agreement for consulting services. Among other things, this agreement provided that Aon would "develop/analyze/provide results of RFP's as necessary to ensure highest quality/lowest cost coverage." The agreement contained no reference to contingent commissions. During the relevant time period, Aon also transmitted to City of Danbury insurance policies and various other communications related to those policies. These materials misrepresented the nature of the services provided by Aon. In addition, the documents failed to adequately disclose the compensation arrangements Aon had with Aon Enterprise Insurer Defendants for the payment of contingent commissions. Moreover, these documents failed to adequately disclose that the undisclosed compensation payments that Aon was receiving

from Aon Enterprise Insurer Defendants destroyed any objectivity that Aon may have had advising the City of Danbury and other clients and constituted a breach of Aon's fiduciary duty. The documents also failed to disclose that Aon was allocating business to Aon Enterprise Insurer Defendants who had agreed to pay contingent commissions.

Aon did not disclose the following material facts in any of its communications with clients:

- that Aon was not acting in the best interest of its clients but was instead acting on behalf of itself and its partner carriers to further their financial interests at the expense of Aon's clients;
- the true nature of the association and agreements between Aon and the Aon Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between Aon and the Aon Enterprise Insurer Defendants;
- Aon's consolidation of its insurance markets to a few select strategic partners;
- Aon's steering of insurance placements to the Aon Enterprise Insurer Defendants, its strategic partners;
- that the Aon Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Aon in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that the kickbacks to Aon are factored into the cost of Plaintiffs and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

Aon's misrepresentation of its allegiance to its client's interests and concealment of Aon's allocation of business to a limited number of partner Insurer Defendants was necessary to encourage clients to retain Aon, to conceal the scheme, to lull clients, including Plaintiffs and Class Members, into a false sense of security and to assure payment of the excess premiums. Likewise, inclusion of the excess amount of premium resulting from Aon and the Insurer Defendants' scheme in invoices forwarded to each Plaintiff without explanation or a separate

accounting for the excess premium was necessary to conceal the scheme and to assure payment of the entire invoice amount.

The fraudulent scheme and the conspiracy in furtherance of the scheme proximately caused the cost of insurance obtained by Plaintiffs and Class Members to increase because the kickbacks paid to Aon were included in the price of insurance paid by Plaintiffs and Class Members. In addition, Plaintiffs and Class Members reasonably relied on Aon's representations and omissions in paying higher premiums that included the kickbacks to Aon.

Despite Aon's duties to its clients, despite Aon's acknowledgement of its obligations and despite Aon's representations, Aon did not act in its clients' best interests but instead engaged in a fraudulent scheme designed to increase the profits of Aon and its insurer partners at the expense of its clients.

Gallagher Enterprise Defendants

Gallagher and the Gallagher Enterprise Insurer Defendants have violated 18 U.S.C. § 1341 and 18 U.S.C. § 1343 by utilizing or causing the use of the United States postal service, commercial interstate carrier, wire or other interstate electronic media in furtherance of their fraudulent scheme.

Defendants have engaged in a scheme whereby Gallagher would steer business to a limited number of partner Insurer Defendants in exchange for kickbacks in the form of contingent commissions and/or other payments which were factored into the premiums paid by plaintiffs and class members. Specifically, as set forth in further detail in the Particularized Statement and the Complaint, Gallagher in conjunction with the Gallagher Enterprise Insurer Defendants engaged in the following conduct:

- Gallagher significantly consolidated the number of carriers to which it would market its clients' business.
- Gallagher then entered into "strategic partnerships" with the Gallagher Enterprise Insurer Defendants to which Gallagher agreed to steer the bulk of its business.
- As strategic partners, the Gallagher Enterprise Insurer Defendants would be given access to a guaranteed flow of premium volume from Gallagher, as well as protection from normal competition from both inside and outside of the strategic partnership for renewal of each Insurer Defendant's own business.
- In order to accomplish this, Gallagher and the Gallagher Enterprise Insurer Defendants engaged in a number of practices specifically set forth in the Revised Particularized Statements including agreements not to bid renewals competitively, limiting the marketing of renewals and other actions designed to maximize the volume of insurance placed with the Gallagher Enterprise Insurer Defendants;
- Gallagher and the Gallagher Enterprise Insurer Defendants provided materially misleading Form 5500 certifications and documents to plan administrators;
- In exchange for, or because of, being given these unfair competitive advantages, the Gallagher Enterprise Insurer Defendants agreed to pay kickbacks to Gallagher.

In furtherance of the scheme, Gallagher and the Gallagher Enterprise Insurer Defendants have sent matters and things through the mail and wire or have known that mail or wire would be used in furtherance of the scheme. Materials sent by mail or wire have included correspondence, emails, faxes, marketing materials, contracts or agreements between Gallagher and the client, requests for proposals, policies and policy materials, insurance quotes, Form 5500 Schedule A

documents and certifications, contingent commission agreements, insurance binders, commission schedules, invoices to clients and payments from insurers to brokers.

Gallagher and the Gallagher Enterprise Insurer Defendants have frequently communicated with each other by mail and/or wire in furtherance of the scheme. Such communications have included contingent commission agreements, letters, faxes and emails memorializing various agreements between Gallagher and its partner markets and details regarding consolidation, requests for bids and bids, invoices, and contingent payments. Many instances of these types of communications are further detailed in the Revised Particularized Statement and the Second Amended Complaint.

Defendants' scheme conflicts with Gallagher's duties and representations to its clients. Gallagher is retained by its clients, including Plaintiffs and Class Members, for the sole purpose of acting on behalf of and providing the clients with unbiased advice concerning the type, amount and level of insurance needed, as well as to provide sound and accurate advice regarding the insurance companies they recommend.

Additionally, Gallagher is a fiduciary of its clients, and therefore owes its clients, including Plaintiffs and other members of the Class: (i) a duty of loyalty to act in the best interests of its clients and to always put its clients' interests ahead of its own; (ii) a duty of full and fair disclosure and complete candor in connection with any insurance-related products purchased by clients or services rendered by Gallagher, including the duty to disclose the source and amounts of all income it receives in or as a result of any transaction involving its clients; (iii) a duty of care in connection with any insurance-related products purchased by its clients or services rendered by Gallagher; (iv) a duty to provide impartial advice in connection with any insurance-related products purchased by its clients or services rendered by Gallagher; (v) a duty

to use its best business judgment in connection with any insurance-related products or services purchased by their clients – in other words to find the best coverage at the lowest price; and, (vi) a duty of good faith and fair dealing.

In a November 3, 2004 letter to Gallagher's "Valued Clients", J. Patrick Gallagher reaffirmed Gallagher's duty to act on behalf of its clients:

> For 77 years, the leaders and employees of this company have always understood that to succeed as an enterprise we must put customers first….I'd like to take this opportunity to reiterate that we view ourselves as your advocates in the marketplace. We want there to be absolutely no confusion about our priorities. Our employees understand that clients come first at Gallagher.

As a result of the nature of the relationship between Gallagher and its clients, as a result of Gallagher's fiduciary status and as a result of Gallagher's representations, Gallagher had a duty to fully disclose any conflicts of interest it had in providing services to their clients as well as any material information that might impact their ability to act in its client's best interest. Gallagher, however, did not disclose its conflicts of interest, its allocation of business to a limited number of insurer partners or the resulting harm to its clients.

Instead, Gallagher in communications with clients simply reinforced that it was acting in its clients' interests. Gallagher's communications with its clients, including Plaintiffs, which contained material misrepresentations and/or omissions are evidenced by the examples set forth herein. To the extent Gallagher provided any information regarding contingent commission income or Gallagher's relationship with the Gallagher Enterprise Insurer Defendants the information was either materially false or misleading. Gallagher routinely represented that it would use its "best efforts" in providing brokerage services to its clients. For example, on or about January 6, 2003, Arthur J. Gallagher ("Gallagher") sent Clear Lam a "Fee Agreement" stating that "Gallagher will provide insurance brokerage services to Client and will use its best

efforts to secure insurance required for the proper administration of Client's business." The Fee Agreement further provides as follows:

> Gallagher shall receive its usual and customary brokerage commission for the services provided hereunder. Gallagher will be charging a fee of $29,766 for brokerage and administration services, in addition to 15% commission on boiler and machinery coverage, 7.5% on pollution liability and 1% commission on auto coverage (already included in the premiums proposed)….
>
> In addition to the fees (commissions) provided herein, it is understood and agreed that other parties, such as excess and surplus lines brokers, wholesalers, reinsurance intermediaries, underwriting managers, and similar parties, some of which may be owned in whole or in part by Gallagher's corporate parent, may earn and retain usual and customary commissions and fees in the course of providing insurance products to client pursuant to this Agreement. Any such fees or commission will not constitute compensation to Gallagher….
>
> Gallagher from time to time enters into arrangements with certain insurance carriers or those carriers' reinsurers providing for compensation, in addition to commissions, to be paid by such carriers or reinsurers to Gallagher or its affiliates based on, among other things, the volume of premium and/or underwriting profitability of the insurance coverages written through Gallagher by such carriers or reinsurers. In addition, Gallagher and its affiliates provide management and other services to, and receive compensation for those services from, certain reinsurers that reinsurer insurance coverages written through Gallagher by other insurance carriers. The insurance coverages you purchase through Gallagher might be issued by an insurance carrier or reinsured by a reinsurer that has such a relationship with Gallagher or its affiliates.

This statement was insufficient to fully disclose Gallagher's compensation arrangements with the Gallagher Enterprise Insurer Defendants noting only that Gallagher has agreements with "certain" insurers and that the client's policies "might" be issued by one of those carriers while failing to provide any information regarding the strategic partnerships that Gallagher had entered into with the Gallagher Enterprise Insurer Defendants or the significance these partnerships and the contingent payment arrangements had on the insurance placement process and the premiums charged. Gallagher also sent Plaintiff Clear Lam an "Insurance Proposal" with an effective date

of December 2003 in which Gallagher again indicated that it would "use its best efforts" on Clear Lam's behalf.

Gallagher also routinely sent invoices to its clients which included the excess premiums resulting from Defendants' scheme without a separate accounting of the excess amount being invoiced. For example, on April 4 and April 5, 2003, Gallagher transmitted invoices to Clear Lam which did not separately account for contingent commission payments and in no way referenced contingent commission income.

Gallagher did not disclose the following material facts in any of its communications to clients:

- that Gallagher was not acting in the best interest of its clients but was instead acting on behalf of itself and its partner carriers to further their financial interests at the expense of Gallagher's clients;
- the true nature of the association and agreements between Gallagher and the Gallagher Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between Gallagher and the Gallagher Enterprise Insurer Defendants;
- Gallagher's consolidation of its insurance markets to a few select strategic partners;
- Gallagher's steering of insurance placements to the Gallagher Enterprise Insurer Defendants, its strategic partners;
- that Gallagher was protecting the Gallagher Enterprise Insurer Defendants from competition
- that the Gallagher Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Gallagher in the form of contingent commissions, loans,

subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;

- that the kickbacks to Gallagher are factored into the cost of Plaintiffs and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

Gallagher's misrepresentation of its allegiance to its client's interests and concealment of Gallagher's allocation of business to a limited number of partner Insurer Defendants was necessary to encourage clients to retain Gallagher, to conceal the scheme, to lull clients, including Plaintiffs and Class Members, into a false sense of security and to assure payment of the excess premiums. Likewise, inclusion of the excess amount of premium resulting from Gallagher and the Insurer Defendants' scheme in invoices forwarded to each Plaintiff without explanation or a separate accounting for the excess premium was necessary to conceal the scheme and to assure payment of the entire invoice amount.

The fraudulent scheme and the conspiracy in furtherance of the scheme proximately caused the cost of insurance obtained by Plaintiffs and Class Members to increase because the kickbacks paid to Gallagher were included in the price of insurance paid by Plaintiffs and Class Members. In addition, Plaintiffs and Class Members reasonably relied on Gallagher's representations and the Defendants' omissions in paying higher premiums that included the kickbacks to Gallagher.

Despite Gallagher's duties to its clients, despite Gallagher's acknowledgement of its obligations and despite Gallagher's representations, Gallagher did not act in its clients' best interests but instead engaged in a fraudulent scheme designed to increase the profits of Gallagher and its insurer partners at the expense of its clients.

Willis Enterprise Defendants

Willis and the Willis Enterprise Insurer Defendants have violated 18 U.S.C. § 1341 and 18 U.S.C. § 1343 by utilizing or causing the use of the United States postal service, commercial interstate carrier, wire or other interstate electronic media in furtherance of their fraudulent scheme.

Defendants have engaged in a scheme whereby Willis would allocate business to a limited number of partner Insurer Defendants in exchange for kickbacks in the form of contingent commissions and/or other payments which were factored into the premiums paid by plaintiffs and class members. Specifically, as set forth in further detail in the Particularized Statement and the Complaint, Willis in conjunction with the Willis Enterprise Insurer Defendants engaged in the following conduct:

- Willis significantly consolidated the number of carriers to which it would market its clients' business.
- Willis entered into "strategic partnerships" with the Willis Enterprise Insurer Defendants to which Willis agreed to steer the bulk of its business.
- As strategic partners, the Willis Enterprise Insurer Defendants would be given access to a guaranteed flow of premium volume from Willis, as well as protection from normal competition from both inside and outside of the strategic partnership for renewal of each Insurer Defendant's own business.
- In order to accomplish this, Willis and the Willis Enterprise Insurer Defendants engaged in a number of practices specifically set forth in the Revised Particularized Statements including agreements not to bid renewals competitively, limiting the

marketing of renewals and other actions designed to maximize the volume of insurance placed with the Willis Enterprise Insurer Defendants.

- Willis and the Willis Enterprise Insurer Defendants provided materially misleading Form 5500 certifications and documents to plan administrators.
- In exchange for, or because of, being given these unfair competitive advantages, the Willis Enterprise Insurer Defendants agreed to pay kickbacks to Willis.

In furtherance of the scheme, Willis and the Willis Enterprise Insurer Defendants have sent matters and things through the mail and wire or have known that mail or wire would be used in furtherance of the scheme. Materials sent by mail or wire have included correspondence, emails, faxes, marketing materials, contracts or agreements between Willis and the client, requests for proposals, policies and policy materials, insurance quotes, Form 5500 Schedule A documents and certifications, contingent commission agreements, insurance binders, commission schedules, invoices to clients and payments from insurers to brokers.

Willis and the Willis Enterprise Insurer Defendants have frequently communicated with each other by mail and/or wire in furtherance of the scheme. Such communications have included contingent commission agreements, letters, faxes and emails memorializing various agreements between Willis and its partner markets and details regarding consolidation, requests for bids and bids, invoices, and contingent payments. Many instances of these types of communications are further detailed in the Revised Particularized Statement and the Second Amended Complaint.

Defendants' scheme conflicts with Willis' duties and representations to its clients. Willis is retained by its clients, including Plaintiffs and Class Members, for the sole purpose of acting on behalf of and providing the clients with unbiased advice concerning the type, amount and

level of insurance needed, as well as to provide sound and accurate advice regarding the insurance companies they recommend.

Additionally, Willis is a fiduciary of its clients, and therefore owes its clients, including Plaintiffs and other members of the Class: (i) a duty of loyalty to act in the best interests of its clients and to always put its clients' interests ahead of its own; (ii) a duty of full and fair disclosure and complete candor in connection with any insurance-related products purchased by clients or services rendered by Willis, including the duty to disclose the source and amounts of all income it receives in or as a result of any transaction involving its clients; (iii) a duty of care in connection with any insurance-related products purchased by its clients or services rendered by Willis; (iv) a duty to provide impartial advice in connection with any insurance-related products purchased by its clients or services rendered by Willis; (v) a duty to use its best business judgment in connection with any insurance-related products or services purchased by their clients – in other words to find the best coverage at the lowest price; and, (vi) a duty of good faith and fair dealing.

As a result of the nature of the relationship between Willis and its clients, as a result of Willis' fiduciary status and as a result of Willis' representations, Willis had a duty to fully disclose any conflicts of interest it had in providing services to their clients as well as any material information that might impact their ability to act in its client's best interest. Willis, however, did not disclose its conflicts of interest, its allocation of business to a limited number of insurer partners or the resulting harm to its clients.

Since the announcement of the regulatory investigations, Willis has acknowledged and reaffirmed its duty to act on behalf of its clients. In an October 22, 2004 letter to "all Clients of Willis Group Holdings" Joseph J. Plumeri, Chairman and Chief Executive Officer of Willis

Group Holdings Ltd. stated, "Willis continues to run its business by a basic principle: Our first priority is our clients. We represent you and conduct business in your best interest utilizing our global resources….Willis represents the client's best interests through a Client Advocate….Willis' recommendations and solutions will be driven by what is in the client's best interests." Willis also reaffirmed that the clients Willis represents are Willis' continuing priority in an October 27, 2004 communication to CEOs, CFOs, Treasurers, Risk Managers and Human Resource Managers.

Prior to the announcement of the investigations, Willis in a September 15, 2003 news release discussed its "client advocacy model", referring to clients as "partner[s] in the insurance placement process" and promising "access to the Markets on a worldwide basis" and "the best insurance program available from the worldwide insurance marketplace." Willis likewise lauded "constant coordination and communication between client, producer, marketer and carrier."

Beginning in or about September 2001, the invoices sent by Willis to clients contained language stating only that "it is possible" that Willis "may receive contingent payments or allowances from insurers based on factors which are not client-specific, such as the size or performance of an overall book of business produced with an insurer by us." This statement was insufficient to fully disclose Willis' compensation arrangements with Willis Enterprise Insurer Defendants, noting only that "it is possible" that Willis may have agreements with Willis Enterprise Insurer Defendants from which Willis could derive additional income while failing to provide any information regarding the strategic partnerships and the contingent payment arrangements had on the insurance placement process and the premiums charged.

During the relevant time period, Willis also transmitted to its clients, including Plaintiffs, various other communications relating to Willis' provision of brokerage services. Willis disclosed none of the following material facts in any of its communications to clients:

- that Willis was not acting in the best interest of its clients but was instead acting on behalf of itself and its partner carriers to further their financial interests at the expense of Willis' clients;
- the true nature of the association and agreements between Willis and the Willis Enterprise Insurer Defendants;
- the conflict of interest inherent in the agreements between Willis and the Willis Enterprise Insurer Defendants;
- Willis' consolidation of its insurance markets to a few select strategic partners;
- Willis' steering of insurance placements to the Willis Enterprise Insurer Defendants, its strategic partners;
- that Willis was protecting the Willis Enterprise Insurer Defendants from competition;
- that the Willis Enterprise Insurer Defendants kick back a substantial portion of their increased profits to Willis in the form of contingent commissions, loans, subsidies and payments for "services" as well as other agreements and tying arrangements that serve the same function;
- that the kickbacks to Willis are factored into the cost of Plaintiffs and Class Members' insurance, resulting in injury to Plaintiffs' and Class Members' business and property.

Willis' representation that Willis was acting on behalf of its client and concealment of Willis's allocation of business to a limited number of partner Insurer Defendants was necessary

to encourage clients to retain Willis, to conceal the scheme, to lull clients, including Plaintiffs and Class Members, into a false sense of security and to assure payment of the excess premiums. Likewise, inclusion of the excess amount of premium resulting from Willis and the Insurer Defendants' scheme in invoices forwarded to each Plaintiff without explanation or a separate accounting for the excess premium was necessary to conceal the scheme and to assure payment of the entire invoice amount.

Despite Willis' duties to its clients, despite Willis' acknowledgement of its obligations and despite Willis' representations, Willis did not act in its clients' best interests but instead engaged in a fraudulent scheme designed to increase the profits of Willis and its insurer partners at the expense of its clients.

The fraudulent scheme and the conspiracy in furtherance of the scheme proximately caused the cost of insurance obtained by Plaintiffs and Class Members to increase because the kickbacks paid to Willis were included in the price of insurance paid by Plaintiffs and Class Members. In addition, Plaintiffs and Class Members reasonably relied on the Willis's representations and the Defendants' omissions in paying higher premiums that included the kickbacks to Willis.

d. State whether there has been a criminal conviction in regard to the predicate acts;

To date, there have been ten criminal convictions in connection with similar conduct in the commercial insurance market:

a. *People v. Patricia Abrams* (N.Y. County Supreme Court) (felony complaint against former ACE executive resulting in guilty plea entered on or about October 14, 2004);

b. *People v. Karen Radke* (N.Y. County Supreme Court) (felony complaint against former AIG executive resulting in guilty plea entered on or about October 14, 2004);

c. *People v. Jean-Baptiste Tateossian* (N.Y. County Supreme Court) (felony complaint against former AIG executive resulting in guilty plea entered on or about October 14, 2004);

d. *People v. John Keenan* (N.Y. County Supreme Court) (felony complaint against former Zurich American Insurance Company executive resulting in guilty plea entered on or about November 16, 2004);

e. *People v. Edward Coughlin* (N.Y. County Supreme Court) (felony complaint against former Zurich American Insurance Company executive resulting in guilty plea entered on or about November 16, 2004);

f. *People v. Robert Stearns* (N.Y. County Supreme Court) (felony complaint against former Marsh executive resulting in guilty plea entered on or about January 4, 2005);

g. *People v. Carlos Coello* (N.Y. County Supreme Court) (felony complaint against former AIG executive resulting in guilty plea entered on or about January 19, 2005);

h. *People v. John Mohs* (N.Y. County Supreme Court) (felony complaint against former AIG executive resulting in guilty plea entered on or about January 25, 2005);

i. *People v. Joshua M. Bewlay* (N.Y. County Supreme Court) (felony complaint against former Marsh executive resulting in guilty plea entered on or about February 14, 2005); and

j. *People v. Kathryn Winter* (N.Y. County Supreme Court) (felony complaint against former Marsh executive resulting in guilty plea entered on or about February 18, 2005).

k. *People v. Todd Murphy* (N.Y. County Supreme Court) (felony complaint against former Marsh executive resulting in guilty plea entered on or about July 29, 2005).

l. *People v. Kevin Bott* (N.Y. County Supreme Court) (felony complaint against former Liberty Mutual executive resulting in guilty plea entered on or about August 2, 2005).

m. *People v. Nicole Michaels* (N.Y. County Supreme Court) (felony complaint against former Marsh executive resulting in guilty plea entered on or about August 3, 2005).

n. *People v. James Spiegel* (N.Y. County Supreme Court) (felony complaint against former Zurich executive resulting in guilty plea entered on or about August 3, 2005).

In addition, the following persons have now been indicted:

Greg Doherty

Kathleen Drake

William Gilman

Thomas T. Green

Edward Keane Jr.

William McBurnie

Edward McNenny

Joseph Peiser

e. State whether civil litigation has resulted in a judgment in regard to the predicate acts;

A number of the Defendants have settled with regulators for the conduct at issue in this case, as set forth in more detail in the Second Amended Complaint.

f. Describe how the predicate acts form a "pattern of racketeering activity"; and

Defendants' predicate acts form a "pattern of racketeering activity" consisting of multiple related acts of racketeering activity since at least the late 1990's. Each and every predicate act of mail and wire fraud was related in that the purpose of each was to prevent detection of the scheme involving allocation of business to the insurer Defendants. Each predicate act involved the same or similar participants – the Broker Defendant and the Insurer Defendants associated with each broker-centered enterprise. Each predicate act involved the same method of commission including the transmittal of documents to the Broker Defendants' clients which included misrepresentations and omissions aimed at preventing detection of the Defendants' scheme. The predicate acts had the similar result of obscuring Defendants' activities and impacted similar victims – the clients of the Broker Defendants, including Plaintiffs and

Members of the Class. The predicate acts amount to continued racketeering activity in that the predicate acts occurred repeatedly over an extended period of time, beginning in the late 1990's. Further, each Insurer defendant habitually, and at the request of the Broker Defendants either failed to report commissions, fees and payments altogether on Form 5500, Schedule A, or Accordingly, these predicate acts constitute a "pattern of racketeering activity."

Additionally, the pattern of racketeering activity included repeated payments of kickbacks and/or other things of value because of, or with the intent to influence, decisions related to an ERISA governed plan. Defendants offered and accepted these payments as part of an illegal kick back scheme in violation of 18 U.S.C. § 1954. The concealment of this unlawful influence was in and of itself a pattern of racketeering activity, in addition to the pattern of racketeering activity undertaken in the offer and acceptance of payment of monies and other things in value because of, or intended to influence, the advice given by the Broker Defendants

g. State whether the alleged predicate acts relate to each other as part of a common plan. If so, describe in detail.

The predicate acts of mail fraud, wire fraud and unlawful influence (§1954) were part of a common plan whereby the Broker Defendants would allocate business to the Insurer Defendants associated with the Broker centered Enterprise in exchange for kickbacks in the form of contingent commissions and/or other payments and whereby the Broker Defendants and the insurers concealed the scheme from customers.

6. State whether the existence of an "enterprise" is alleged within the meaning of 18 U.S.C. § 1961(4). If so, for each such enterprise, provide the following information:

a. State the names of the individuals, partnerships, corporations, associations or other legal entities, which allegedly constitute the enterprise.

Five associations in fact enterprises are alleged:

a. Marsh, AIG, CIGNA, Hartford, MetLife, Prudential and Unum (the "Marsh Enterprise"). The Marsh Enterprise is an ongoing organization which has existed continuously since the late 1990's;

b. Aon, CIGNA, Hartford, MetLife, Prudential and Unum (the "Aon Enterprise"). The Aon Enterprise is an ongoing organization which has existed continuously since the late 1990's;

c. ULR, CIGNA, Hartford, MetLife, Prudential and Unum (the "ULR Enterprise"). The ULR Enterprise is an ongoing organization which has existed continuously since the late 1990's;

d. Gallagher, AIG, CIGNA, Hartford, MetLife, Prudential and Unum (the "Gallagher Enterprise"). The Gallagher Enterprise is an ongoing organization which has existed continuously since the late 1990's;

e. Willis, CIGNA, Hartford, MetLife, Prudential and Unum (the "Willis Enterprise"). The Willis Enterprise is an ongoing organization which has existed continuously since the late 1990's;

b. Describe the structure, purpose, function and course of conduct of the enterprise;

The purpose of each Enterprise is (1) to make money through the creation of a defined and limited group of insurance carriers to which the broker defendant allocates the insurance business of class members with limited or no competition in exchange for sharing increased profits and (2) to conceal this scheme from customers.

The structure for decision-making within each enterprise includes the following: (1) one or more broker executives who have responsibility and authority for interfacing with the insurers to determine compensation, to plan for the steering or retention of business, and to monitor and direct that business be retained or steered to insurer members of the enterprise; (2) broker account executives who implement direction regarding the retention or steering of business; (3) one or more executives at each insurer who have the responsibility and authority to plan with the broker, to monitor the placement of business and to determine compensation for the steering or retention of business; (4) an employee or employees of the insurer who monitor(s) and reports

placement volume to insurer executives as well as the broker; (5) an employee or employees of the broker who keeps track of reports received from the insurers regarding placement volume; (6) an employee or employees who implement decisions regarding the placement of business; and (7) an employee or employee who factor(s) the cost of the kickbacks into the insurance premiums paid by Plaintiffs and Class Members; (8) employees of the insurer who falsely, or inaccurately, report and certify the payments or other things of value given to brokers who represented the Plans by insurers to ERISA plan's and/or plan administrator for inclusion on Form 5500, Schedule A. In addition, the broker assumes primary responsibility for concealment of the scheme; however, the insurer members of the enterprise also conceal the scheme by falsely underreporting the amounts of commissions paid to the brokers on Form 5500s.

Each enterprise has undertaken a course of conduct to develop, coordinate, monitor and conceal the fraudulent scheme.

c. State whether any defendants are employees, officers or directors of the alleged enterprise;

Defendants are not employees, officers or directors of the Enterprise.

d. State whether any defendants are associated with the alleged enterprise;

Defendants are associated with the enterprises and participate and control the affairs of the enterprises. Defendants' control and participation in the enterprise is necessary for the successful operation of Defendants' scheme. While defendants participate in and are members of the enterprises, defendants also have an existence separate and distinct from the enterprises.

Marsh and AIG, CIGNA, Hartford, MetLife, Prudential and Unum are all associated with, participate in and control the affairs of the Marsh Enterprise.

ULR and CIGNA, Hartford, MetLife, Prudential, and Unum are all associated with, participate in and control the affairs of the ULR Enterprise.

Aon and CIGNA, Hartford, MetLife, Prudential, and Unum are all associated with, participate in and control the affairs of the Aon Enterprise.

Gallagher and AIG, CIGNA, Hartford, MetLife, Prudential and Unum are all associated with, participate in and control the affairs of the Gallagher Enterprise.

Willis and CIGNA, Hartford, MetLife, Prudential, and Unum are all associated with, participate in and control the affairs of the Willis Enterprise.

e. State whether you are alleging that the defendants are individuals or entities separate from the alleged enterprise, or that the defendants are the enterprise itself, or members of the enterprise; and

While these Defendants participate in and are members of each enterprise as indicated above, they have an existence separate and distinct from the enterprise.

f. If any defendants are alleged to be the enterprise itself, or members of the enterprise, explain whether such defendants are perpetrators, passive instruments, or victims of the alleged racketeering activity.

Defendants are perpetrators of the racketeering activity.

7. State and describe in detail whether you are alleging that the pattern of racketeering activity and the enterprise are separate or have merged into one entity.

The racketeering activity and the enterprise are separate. The members of each Enterprise share a common purpose and each Enterprise is continuing and has a structure for decision-making and for oversight, coordination and facilitation of the predicate offenses. The pattern of racketeering activity includes numerous acts of mail and wire fraud, as well as § 1954 unlawful influence violations in furtherance of a fraudulent scheme whereby the Broker steers business to the Insurer members in exchange for kickbacks in the form of contingent commissions and/or other payments.

Each broker-centered enterprise is comprised of the (1) the Broker Defendant and (2) the Broker Defendant's strategic insurance partners. As set forth in detail above, the members of each Broker-centered Enterprise share a common purpose and the Enterprise is continuing and has a structure for decision-making. The pattern of racketeering activity includes numerous acts of mail and wire fraud in furtherance of a fraudulent scheme whereby the Broker Defendants steer business to a few "strategic" insurance partners, including the Defendant Insurers, in exchange for kickbacks of the resulting profits. Additionally, the pattern of racketeering includes repeatedly payments of kickbacks and/or other things of value because of or with the intent to influence decisions related to an ERISA governed plan. Defendants concealed these payments as part of the illegal kick back scheme in violation of 18 U.S.C. § 1954.

8. Describe the alleged relationship between the activities of the enterprise and the pattern of racketeering activity. Discuss how the racketeering activity differs from the usual and daily activities of the enterprise, if at all.

Each Enterprise oversees, coordinates and facilitates the commission of numerous predicate offenses. The daily activities of the enterprise include some legitimate activities relating to the distribution of insurance on a competitive basis. The racketeering activity is comprised of a fraudulent scheme to allocate business on a noncompetitive basis resulting in additional profits for all Defendants as well as concealment of the scheme.

9. Described what benefits, if any, the alleged enterprise receives from the alleged pattern of racketeering.

Each Enterprise benefits from the pattern of racketeering through reduced competition and additional profits as well as concealment of the scheme.

10. Describe the effect of the activities of the enterprise on interstate or foreign commerce.

Each Enterprise operates on a nation-wide basis and utilizes interstate communications including United States mail and wire across state lines. The activities of the enterprises are

national in scope, affecting most of the commercial insurance market in the United States. The enterprises have a substantial impact upon the economy and upon interstate commerce.

11. If the complaint alleges a violation of 18 U.S.C. § 1962(a), provide the following information:

Plaintiffs do not allege a violation of 18 U.S.C. § 1962(a).

a. State who received the income derived from the pattern of racketeering activity or through the collection of an unlawful debt; and

Not applicable.

b. Describe the use or investment of such income.

Not applicable.

12. If the complaint alleges a violation of 18 U.S.C. § 1962(b), describe in detail the acquisition or maintenance of any interest in or control of the alleged enterprise.

Plaintiffs do not allege a violation of 18 U.S.C. § 1962(b).

13. If the complaint alleges a violation of 18 U.S.C. § 1962(c), provide the following information:

a. State who is employed by or associated with the enterprise; and

Marsh Enterprise – Marsh and AIG, CIGNA, Hartford, MetLife, Prudential and Unum.

ULR Enterprise – ULR and, CIGNA, Hartford, MetLife, Prudential and Unum.

Aon Enterprise – Aon and CIGNA, Hartford, MetLife, Prudential and Unum.

Gallagher Enterprise – Gallagher and AIG, CIGNA, Hartford, MetLife, Prudential and Unum

Willis Enterprise –Willis and AIG, CIGNA, Hartford, MetLife, Prudential and Unum

b. State whether the same entity is both the liable "person" and the "enterprise" under § 1962(c).

The same entity is not both the liable person and the enterprise under § 1962(c).

c. Describe specifically how the defendant(s) participated in the operation or management of the enterprise.

As set forth herein, each Defendant had officers and employees who had responsibility for participating in, operating and managing each enterprise. More specifically, Defendants participated in each enterprise by developing and agreeing to methods for concealment of the fraudulent scheme, by agreement regarding the allocation of business and resulting kickbacks and by providing information regarding accounts and regarding the placement of business.

Broker Defendants have participated in the operation or management of each Enterprise in at least the following ways:

a. by developing methods for concealment of the fraudulent scheme;

b. by submitting false or misleading information to customers;

c. by consolidating markets and steering business to strategic insurance partners;

d. by bid rigging

e. by sharing information relating to such matters as market conditions, placements and payments;

f. by accepting compensation with the intent of being influenced as to the advice they provide to ERISA plans, plan sponsors, class members and/or plan participants.

The Insurer Defendants participated in the operation or management of the Enterprise in at least the following ways:

a. by developing methods for concealment of the fraudulent scheme;

b. by kicking back profits to the Broker Defendants;

c. by submitting false or misleading information to customers or to brokers for submission to customers;

d. by providing or withholding quotes as directed by Broker Defendants;

e. by sharing information relating to such matters as market conditions, placements and payments;

f. by offering and paying commissions and/or other things of value with the intent of influencing the advice that the Brokers rendered to the ERISA plans, plan sponsor and/or plan participants.

g. by falsely certifying to ERISA plan's and/or plan administrator the amount of commissions or other thing of values paid to the Brokers who represented the Plans. The false representation allowed the concealment of contingent commissions from the plan sponsor, plan administrator and plan participants (i.e. ERISA class members). If properly reported, the total commission would have appeared on the Form 5500's which are documents available to the plan sponsors, plan administrators and plan participants;

h. by spreading commissions and other things of value across the books in an attempt to obscure and misrepresent the payments and/or avoid reporting and certification requirements

14. If the complaint alleges a violation of 18 U.S.C. § 1962(d), describe in detail the alleged conspiracy.

Plaintiffs allege the following conspiracies:

The Broker Defendant Conspiracy:

Marsh, Aon, Gallagher, Willis, USI and ULR have conspired to facilitate the scheme being operated through each of the Broker-Centered Enterprises identified above and to further their common purpose of preventing detection of these schemes through misrepresentations, concealment and coordinated and controlled disclosures.

The Broker Defendants conspiracy has been conducted, implemented and facilitated through the sharing of information among the Broker Defendants and through Marsh, Aon, USI,

Willis, and Gallagher's participation in CIAB. As alleged above, during the Class Period, each of the Broker Defendants except ULR was a member of CIAB and served on its Board of Directors and/or as officers of CIAB. Additionally, information was exchanged among the Brokers, including ULR, via the Insurer Defendants.

The purpose and effect of the conspiracy was to prevent Plaintiffs and members of the Class from becoming aware of the terms and significance of the contingent commission agreements between the Defendants and the conflicts of interest arising out of the Broker Defendants' strategic partnerships with the Insurer Defendants, thereby allowing the Broker Defendants to increase the compensation they received from the Insurer Defendants.

The Broker Defendants accomplished this by conspiring with one another to adopt substantially similar vague and incomplete disclosure (or non-disclosure) policies regarding contingent compensation matters modeled after CIAB's 1998 position statement and by employing CIAB to engage in a public relations campaign designed to create the impression that "full disclosure" was the industry standard and to oppose any efforts to require meaningful disclosure of contingent commission arrangements. Further, the Broker Defendants conspired to encourage the Insurer Defendants to mislead their customers on Form 5500 filings. As described above, through their coordinated efforts, the Broker Defendants successfully were able to prevent insurance purchasers from becoming aware of the true nature of the relationships between the Broker Defendants and the Insurer Defendants and from obtaining actual and complete disclosure of the manner in which the Broker Defendants were compensated by the Insurer Defendants.

Each Broker Defendant was aware of the general nature of the conspiracy and its role in facilitating the objectives of the conspiracy. Further, each Broker Defendant has agreed to the

overall objective of the conspiracy. Each Broker Defendant has committed acts of fraud in furtherance of the alleged conspiratorial objectives. As a result of the Broker Defendants' conspiracy, Plaintiffs and other members of the Class have paid more than they otherwise would have for insurance that they procured through the Broker Defendants.

The Insurer Defendant Conspiracy:

Unum, AIG, Hartford, CIGNA, MetLife and Prudential have all conspired to facilitate the scheme being operated through each of the Broker-Centered Enterprises identified above and to further their common purpose of preventing detection of these schemes through misrepresentations, concealment and coordinated and controlled disclosures.

The Insurer Defendants conspiracy has been conducted, implemented and facilitated through the sharing of information among the Insurer Defendants individually and also collectively through the Insurer Defendants' participation in LIMRA. As alleged in the complaint, during the Class Period, each of the Insurer Defendants was a member of LIMRA and was involved in the use of Insurer surveys regarding disclosure, and specifically Form 5500 disclosure.

The purpose and effect of the conspiracy was to prevent Plaintiffs and members of the Class from becoming aware of the terms and significance of the contingent commission agreements between the Defendants and the conflicts of interest arising out of the Broker Defendants' strategic partnerships with the Insurer Defendants, thereby allowing the Insurer Defendants to increase the amount of business received from the Broker Defendants.

The Insurer Defendants accomplished this by conspiring with one another to adopt similar vague and incomplete disclosure (or non-disclosure) policies, and communicating about the fee and commission arrangements being offered to the Broker Defendants. Further, in light

of these communications, Insurer Defendants conspired to offer "competitive" contingent commission agreements which were designed to help disguise the payments to Brokers and prevent disclosure of the scheme and keep them off Form 5500 documents. As described in the complaint, through their coordinated efforts, the Insurer Defendants successfully were able to prevent insurance purchasers from becoming aware of the true nature of the relationships between the Broker Defendants and the Insurer Defendants and from obtaining actual and complete disclosure of the manner in which the Broker Defendants were compensated by the Insurer Defendants.

Each Insurer Defendant was aware of the general nature of the conspiracy and its role in facilitating the objectives of the conspiracy. Further, each Insurer Defendant has agreed to the overall objective of the conspiracy. Each Insurer Defendant has committed acts of fraud in furtherance of the alleged conspiratorial objectives. As a result of the Insurer Defendants' conspiracy, Plaintiffs and other members of the Class have paid more than they otherwise would have for insurance that they procured through the Broker Defendants.

The Broker-Centered Conspiracies:

Additionally, the following broker-centered conspiracies exist:

- A conspiracy involving Marsh and the Marsh Enterprise Insurer Defendants.
- A conspiracy involving Aon and the Aon Enterprise Insurer Defendants.
- A conspiracy involving Gallagher and the Gallagher Enterprise Insurer Defendants.
- A conspiracy involving ULR and the ULR Enterprise Insurer Defendants.
- A conspiracy involving Willis and the Willis Enterprise Insurer Defendants.

The purpose and effect of each broker-centered conspiracy was to engage in a scheme whereby each Broker Defendant would allocate business to its strategic partner Insurer

Defendants and protect them from competition in exchange for increased compensation paid to the Broker Defendant in the form of contingent commissions, and to conceal the existence of the scheme from the Broker Defendant's clients.

Each Defendant within each broker-centered conspiracy was aware of the general nature of the conspiracy and its role in facilitating the objectives of the conspiracy. Further, each Defendant within each broker-centered conspiracy has agreed to the overall objective of the conspiracy. Each Defendant within each broker-centered conspiracy has committed acts of fraud in furtherance of the alleged conspiratorial objectives. As a result of the broker-centered conspiracies, Plaintiffs and other members of the Class have paid more than they otherwise would have for insurance that they procured through the Broker Defendants.

15. Describe the alleged injury to business or property.

Plaintiffs and Class Members have been injured in their business or property by paying excessive premiums for insurance.

16. Describe the direct causal relationship between the alleged injury and the violation of the RICO statute.

The fraudulent scheme and conspiracy involving each Broker Defendant and the Insurer Defendants associated in the broker-centered enterprise with the Broker Defendant and the Broker Conspiracy (between Marsh, Aon, Willis, Gallagher, USI and ULR) as well as the Insurer Conspiracy (between AIG, Unum, Prudential, MetLife, The Hartford and CIGNA) to prevent detection of each broker's fraudulent scheme proximately caused the cost of insurance obtained by, or on behalf of, Plaintiffs and Class Members to increase because the kickbacks paid to the Broker Defendant were included in the price of insurance paid by, or on behalf of, Plaintiffs and Class Members. The offer and acceptance of these kickbacks because of, or with intent to influence, the advice of the Broker Defendants lead to higher premiums being paid by Plaintiffs

and the Class Members. In addition, Plaintiffs and Class Members reasonably relied on the Broker Defendant's representations and omissions in paying higher premiums that included the kickbacks to the Broker Defendant than they would have if the scheme had been fully disclosed.

17. List the damages sustained by reason of the violation of § 1962, indicating the amount for which each defendant is allegedly liable.

Each and every Defendant is jointly and severally liable for treble. The damages for the increased premiums Plaintiffs and Class Members paid or that were paid on behalf of Plaintiffs and Class Members as a result of Defendants' illegal conduct.

18. List all other Federal causes of action, if any, and provide the relevant statute numbers.

The following additional Federal claims have been alleged in the actions currently pending before the Court: Sherman Act, 15 U.S.C. § 1; ERISA Breach of Fiduciary Duty and ERISA Prohibited Transactions 29 U.S.C. § 1104, 29 U.S.C. § 1106, and 29 U.S.C. § 1132, *et seq*.

19. List all pendent state claims, if any.

Plaintiffs allege several state claims for which independent jurisdiction existence pursuant to the Class Action Fairness Act ("CAFA"). These state claims include claims for unjust enrichment and breach of fiduciary duty. Additionally, defendants are alleged to have engaged in unfair competition or unfair, unconscionable, deceptive or fraudulent acts or practices in violation of the state consumer protection statutes listed below.

State Antitrust Laws

Alaska Sta. §§45.50.462 *et seq.*

Arizona Revised Stat. §§44-1401 *et seq.*

Arkansas Stat. Ann. §44-75-309 *et seq.*, §§4-75-201 *et seq.*

Cal. Bus. Prof. Code §§16700 *et seq.*, §§17000 *et seq.*

Colorado Rev. Stat. §§6-4-101 *et seq.*

Connecticut Gen. Stat. §§35-26 *et seq.*

D.C. Code Ann. §§28-4503 *et seq.*

Delaware Code Ann. Tit. 6, §§2103 *et seq.*

Florida Stat. §§501-201 *et seq.*

Georgia Code Ann. §§16-10-22 *et seq*, §§ 13-8-2 *et seq.*

Hawaii Rev. Stat. §§480-1 *et seq.*

Idaho Code §§48-101 *et seq.*

740 Illinois Comp. Stat. §§10/1 *et seq.*

Indiana Code Ann. §§24-1-2-1 *et seq.*

Iowa Code §§553.1 *et seq.*

Kansas Stat. Ann. §§50-101 *et seq.*

Kentucky Rev. Stat. §§367.175 *et seq.*, §446.070

Louisiana Rev. Stat. §§55:137 *et seq.*

Maine Rev. Stat. Ann. 10, §§1101 *et seq.*

Maryland Code Ann. Title 11, §§11-201 *et seq.*

Massachusetts Ann. Laws ch. 92 §§1 *et seq.*

Michigan Comp. Laws. Ann. §§445.773 *et seq.*

Minnesota Stat. §§325D.52 *et seq.*

Mississippi Code Ann. §§75-21-1 *et seq.*

Missouri Stat. Ann. §§416.011 *et seq.*

Montana Code Ann. §§30-14-101 *et seq.*

Nebraska Rev. Stat. §§59-801 *et seq.*

Nev. Rev. Stat. Ann. §§598A *et seq.*

New Hampshire Rev. Stat. Ann. §§356:1 *et seq.*

New Jersey Stat. Ann. §§56:9-1 *et seq.*

New Mexico Stat. Ann. §§57-1-1 *et seq.*

N.Y. Gen. Bus. Law §§340 *et seq*.

North Carolina Gen. Stat. §§75-1 *et seq.*

North Dakota Cent. Code §§51-08.1-01 *et seq.*

Ohio Rev. Code §§1331.01 *et seq.*

Oklahoma Stat. tit. 79 §§203(A) *et seq.*

Oregon Rev. Stat. §§646.705 *et seq.*

Rhode Island Gen. Laws §§6-36-1 *et seq.*

South Carolina Code §§39-1-10 *et seq.*

South Dakota Codified Laws Ann. §§37-1 *et seq.*

Tennessee Code Ann. §§47-25-101 *et seq.*

Texas Bus. & Com. Code §§15.01 *et seq.*

Utah Code Ann. §§76-10-911 *et seq.*

Vermont Stat. Ann. 9 §§2453 *et seq.*

Virginia Code §§59-1-9.2 *et seq.*

Washington Rev. Code §§19.86.010 *et seq.*

West Virginia §§47-18-1 *et seq.*

Wisconsin Stat. §§133.01 *et seq.*

Wyoming Stat. §§40-4-101 *et seq.*

20. Provide any additional information that you feel would be helpful to the Court in processing your RICO claim.

Dated: May 22, 2007

Respectfully submitted,

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