Employers Holdings, Inc.
Form 424B1
January 31, 2007
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PROSPECTUS

Filed pursuant to Rule 424(b)(1)
Registration File No. 333-139092

26,750,000 Shares

COMMON STOCK

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This is our initial public offering of our common stock. This offering is being made in connection with our conversion to a stock corporation from a mutual insurance holding company owned by our policyholder members. Upon the conversion, which will occur prior to the closing of this offering, our name will change from EIG Mutual Holding Company to Employers Holdings, Inc. Prior to this offering, there has been no public market for our common stock.

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In addition to the shares offered by this prospectus, we will issue an estimated 25,965,221 shares of our common stock to our members entitled to receive shares in the conversion in exchange for the extinguishment of their membership interests in our company.

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Our common stock has been approved for listing, subject to official notice of issuance, on the New York Stock Exchange under the symbol ‘‘EIG.’’

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Investing in our common stock involves risks. See ‘‘Risk Factors’’ beginning on page 14.

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PRICE $17 A SHARE

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| | Price to Public | Underwriting Discounts and Commissions | Proceeds to Us |
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| Per Share | $17.00 | $1.105 | $15.895 |
| Total | $ 454,750,000 | $ 29,558,750 | $ 425,191,250 |

We have granted the underwriters the right to purchase up to an additional 4,012,500 shares of common stock to cover over-allotments.

None of the Securities and Exchange Commission, any state securities commission and the Nevada Insurance Commissioner has approved or disapproved these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

Morgan Stanley & Co. Incorporated expects to deliver the shares of common stock to purchasers on February 5, 2007.

MORGAN STANLEY

COCHRAN CARONIA WALLER

FOX-PITT, KELTON

KEEFE, BRUYETTE & WOODS

January 30, 2007

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You should rely only on the information contained in this prospectus. We have not, and the underwriters have not,

authorized any other person to provide you with information that is different from that contained in this prospectus. We are offering to sell and are seeking offers to buy these securities only in jurisdictions where offers and sales are permitted. The information contained in this prospectus is accurate only as of the date of this prospectus, regardless of the time of delivery of this prospectus or of any sale of common stock.

Until February 24, 2007, which is the 25th day after the date of this prospectus, all dealers that buy, sell or trade our common stock, whether or not participating in this offering, may be required to deliver a prospectus. This is in addition to the dealers' obligation to deliver a prospectus when acting as underwriters and with respect to their unsold allotments or subscriptions.



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PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus. This summary does not contain all of the information that you should consider before purchasing the common stock offered by this prospectus. You should read the entire prospectus carefully, including the ''Risk Factors'' and ''Forward-Looking Statements and Associated Risks'' sections and our historical consolidated financial statements, and the notes to those financial statements, before making an investment decision. Unless otherwise stated or the context otherwise requires, references in this prospectus to ''we,'' ''our'' or ''us'' refer to EIG Mutual Holding Company and its subsidiaries prior to the effective date of th conversion and to Employers Holdings, Inc. (the successor to EIG Mutual Holding Company in the conversion) and its subsidiaries after the effective date of the conversion and references to ''EIG'' refer solely to EIG Mutual Holding Company prior to the effective date of the conversion and to Employers Holdings, Inc. (the successor to EIG Mutual Holding Company in the conversion) after the effective date of the conversion. All financial information contained in this prospectus, unless otherwise indicated, has been derived from our consolidated financial statements and is presented in conformity with generally accepted accounting principles. The Glossary beginning on page G-1 of this prospectus includes definitions of certain insurance and other terms, such as assumed premiums written, direct premiums written, base direct premiums written, gross premiums written, net premiums written and net premiums earned.

Our Company

Overview

We are a specialty provider of workers' compensation insurance focused on select small businesses engaged in low to medium hazard industries. Our business has historically targeted employers located in several western states, primarily California and Nevada. We believe that the market we serve has, to date, been characterized by fewer competitors, more attractive pricing and strong persistency, or repeat business, when compared to the U.S. workers' compensation insurance industry in general. We distribute our products almost exclusively through independent agents and brokers and our strategic distribution relationships. We had net premiums written (which excludes premiums ceded, or paid, to our reinsurers for transferring all or a portion of risk) of $439.7 million and $299.5 million, total revenues of $496.5 million and $359.2 million, and net income of $137.6 million and $116.5 million for the year ended December 31, 2005 and the nine months ended September 30, 2006, respectively. During 2005, based on net premiums written, we were the largest, seventh largest and seventeenth largest non-governmental writer of workers' compensation insurance in Nevada, California and the United States, respectively, as reported by A.M. Best Company, or A.M. Best. We had total assets of $3.2 billion at September 30, 2006.

The workers' compensation insurance industry historically classified risks into four hazard groups based on severity, with employers in the first, or lowest, group having the lowest cost claims. In 2005, 67% and 31% of our base direct premiums written (which we define as direct premiums written prior to any policy audit or rating adjustments) were generated by employers in the second and third lowest hazard groups, respectively. Direct premiums written is the sum of premiums on all policies issued by our insurance subsidiaries. Within each hazard group, our underwriters use their local market expertise and disciplined underwriting to assess employers and risks on an individual basis and to select those types of employers and risks that allow us to generate attractive returns. We believe that, as a result of our disciplined underwriting standards, we are able to price our policies competitively and profitably.

In 2005, we generated 77.7% and 18.3% of our direct premiums written in California and Nevada, respectively. We also write business in seven other states (Arizona, Colorado, Idaho, Illinois, Montana, Texas and Utah) and are licensed to write business in six additional states (Florida, Maryland, New Mexico, New York, Oregon and Pennsylvania). We market and sell our insurance products through independent local and regional agents and brokers, and through our strategic distribution partners, including our principal partners, ADP, Inc., or ADP, and Blue Cross of California, an operating subsidiary of Wellpoint, Inc., or Wellpoint. In 2005, policies underwritten directly or through our independent agents



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and brokers generated $323.6 million, or 70.6%, of our gross premiums written, while those underwritten through our strategic relationships generated $126.9 million, or 27.7%, of our gross premiums written (which we define as the sum of direct written premiums and assumed premiums written before the effect of ceded reinsurance and the intercompany pooling agreement).

Under the leadership of our senior management team, our net premiums written increased from $187.0 million in 2002 to $439.7 million in 2005, and the total consolidated statutory surplus of our insurance subsidiaries has grown from $224.2 million at year end 2002 to $530.6 million at year end 2005 and $625.9 million at September 30, 2006. Total consolidated statutory surplus is the amount remaining after all liabilities are subtracted from all admitted assets, as determined in accordance with statutory accounting practices. Our average combined ratio on a statutory basis for the same four years was 96.8%. This ratio was lower than the industry composite combined ratio calculated by A.M. Best for U.S. insurance companies having more than 50% of their premiums generated by workers' compensation insurance products. The industry combined ratio on a statutory basis for those companies was 106.8% during the same four years. The combined ratio is a measure used in the property and casualty insurance business to show the profitability of an insurer's underwriting, and it represents the percentage of each premium dollar spent on claims and expenses. The combined ratio is the sum of the losses and loss adjustment expenses, or LAE, ratio, the commission expense ratio and the underwriting and other operating expense ratio. The losses and LAE ratio, commission expense ratio and underwriting and other operating expense ratio express the relationship between losses and LAE (which we define as the expenses of investigating, administering and settling claims (including legal expenses)), commission expense, and underwriting and other operating expenses (including policyholder dividends), respectively, to net premiums earned. When the combined ratio is below 100%, an insurance company experiences underwriting gain, meaning that claims payments, the cost of settling claims, commissions and underwriting expenses are less than premiums collected. If the combined ratio is at or above 100%, an insurance company cannot be profitable without investment income, and may not be profitable if investment income is insufficient. Companies with lower combined ratios than their peers generally experience greater profitability.

As of December 31, 2006, our insurance subsidiaries were assigned a group letter rating of A– (Excellent), with a ‘‘positive’’ financial outlook, by A.M. Best, the fourth highest of 16 ratings. This A.M. Best rating is a financial strength rating designed to reflect our ability to meet our obligations to policyholders. This rating does not refer to our ability to meet non-insurance obligations and is not a recommendation to purchase or discontinue any policy or contract issued by us or to buy, hold or sell our securities.

We commenced operations as a private mutual insurance company on January 1, 2000 when our Nevada insurance subsidiary assumed the assets, liabilities and operations of the Nevada State Industrial Insurance System, or the Fund, pursuant to legislation passed in the 1999 Nevada legislature. The Fund had over 80 years of workers' compensation experience in Nevada. In July 2002, we acquired the renewal rights to a book of workers' compensation insurance business from Fremont Compensation Insurance Group and its affiliates, or collectively, Fremont. Because of the Fremont transaction, we were able to establish our important relationships and distribution agreements with ADP and Wellpoint.

This offering is being made in connection with our conversion to a stock corporation from a mutual insurance holding company owned by our policyholder members. See ‘‘The Conversion.’’

Our Competitive Strengths

We believe we benefit from the following competitive strengths:

Focused Operations. We focus on providing workers' compensation insurance to select small businesses in low to medium hazard groups in specific geographic markets. We believe that this focus provides us with a unique competitive advantage because we are able to gain in-depth customer and market knowledge and expertise. In addition, we believe that we benefit by focusing on small businesses, as they are not generally the principal focus of large insurance companies. As a result, we believe we enjoy





strong persistency and attractive pricing. We have also benefited from the attractive pricing resulting from the bundling of our workers' compensation insurance product with the small group health insurance product marketed to our targeted customers by one of our strategic distribution partners, Wellpoint.

Disciplined Underwriting. We employ a disciplined, conservative and highly automated underwriting approach designed to individually select specific types of employers that we believe will have fewer and less costly claims relative to other employers in the same hazard group. Our underwriting guidelines are designed to minimize underwriting of classes and subclasses of business which have historically demonstrated claims severity that do not meet our target risk profiles. We price our policies based on the specific risks associated with each potential insured rather than solely on the industry class in which such potential insured is classified. In 2005, policyholders in the second lowest industry defined hazard group generated approximately 67% of our base direct premiums written. Our statutory losses and LAE ratio, a measure which relates inversely to our underwriting profitability, was 58.3% in 2005, 18.2 percentage points below the 2005 statutory industry composite losses and LAE ratio calculated by A.M. Best for U.S. insurance companies having more than 50% of their premiums generated by workers' compensation insurance products. Our statutory losses and LAE ratio was at least ten percentage points below the A.M. Best composite losses and LAE ratio for the industry for each of the five years ended December 31, 2005. Our disciplined underwriting approach is a critical element of our culture and has allowed us to realize competitive prices, diversify

our risks and achieve profitable growth.

Long-Standing and Strategic Distribution Relationships. We have established long-standing, strong relationships with independent agents and brokers by emphasizing personal interaction, offering responsive service and competitive commissions and maintaining a focus on workers' compensation insurance. We are able to use these long-standing relationships to identify new business opportunities. Our field underwriters continue to work closely with independent agents and brokers to market and underwrite our business, regularly visit their offices and participate in presentations to customers, which results in enhanced understanding of the businesses and risks we underwrite and the needs of prospective customers. To expand our distribution reach, we have also developed important and long-standing strategic distribution relationships with ADP and Wellpoint and have recently entered into a strategic distribution relationship with E-chx, Inc., or E-chx, a payroll outsourcing company. Through our strategic distribution partnership with ADP, we jointly market our workers' compensation insurance products with ADP's payroll services primarily to small businesses in California, as well as in Colorado, Idaho, Texas and Utah, generating $48.5 million in gross premiums written in 2005. Through our strategic distribution partnership with Wellpoint, we jointly market our workers' compensation insurance products with Wellpoint's group health insurance plans to small businesses in California, generating $78.4 million in gross premiums written in 2005.

Scalable and Cost-Effective Infrastructure. We have three strategic business units overseeing 12 territorial offices serving the various states in which we are currently doing business. We believe we have created an efficient, cost-effective, scalable infrastructure that complements our geographic reach, our focus on workers' compensation insurance and our targeting of small businesses. As part of our cost-effective infrastructure, we have developed a highly automated underwriting software program that allows for electronic submission and review of insurance applications, employing our underwriting standards and guidelines. This automated process leads to efficient and timely processing of applications for small, straight-forward policies that meet our standards and saves our independent agents and brokers considerable time in processing customer applications.

Financial Strength. As of September 30, 2006, our insurance subsidiaries had total consolidated statutory surplus of $625.9 million and, as of December 31, 2006, were assigned a group letter rating of A– (Excellent), with a ''positive'' financial outlook, by A.M. Best, the fourth highest of 16 ratings. The amount of statutory surplus is regarded as financial protection to policyholders in the event an insurance company suffers unexpected or catastrophic losses. We have a proven history of conservative reserving. There have been no prior year adverse developments, or increases in the estimated ultimate losses and LAE from one valuation date to a subsequent valuation date, in our reserves since we commenced operations in 2000. Our insurance subsidiaries' ratio of net premiums written to total consolidated



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statutory surplus, a measure of underwriting leverage, of 0.83:1 at December 31, 2005, compared to an industry average of 1.1:1 at such date, further demonstrates the strength of our balance sheet. In connection with our assumption in 2000 of the assets, liabilities and operations of the Fund, including in force policies and historical liabilities associated with the Fund for losses prior to January 1, 2000, our Nevada insurance subsidiary assumed the Fund's rights and obligations under a retroactive 100% quota share reinsurance agreement (referred to in this prospectus as the LPT Agreement) which the Fund had entered into with third party reinsurers. The LPT Agreement substantially reduced the exposure to losses for pre-July 1995 Nevada insured risks.

Strong Senior Management with Extensive Industry Experience. We have a strong senior management team with significant insurance industry experience across a variety of markets and market conditions. Our executive officers

and senior management team also have significant experience with the state-by-state workers' compensation legislative and regulatory environment, particularly in the states in which we operate or are licensed, and they have been proactive in encouraging legislation that allows us to operate profitably within a balanced framework. Douglas D. Dirks, our President and Chief Executive Officer, and four of our other executive officers have an average of over 18 years of insurance industry experience and over 16 years of workers' compensation insurance experience. Additionally, our senior underwriting and claims managers on average have over 20 years of experience in the insurance industry.

Our Strategies

We plan to pursue profitable growth by focusing on the following strategies:

Maintain Focus on Underwriting Profitability. We are committed to disciplined underwriting, and we will continue this approach in pursuing profitable growth opportunities. We will carefully monitor market trends to assess new business opportunities, only pursuing opportunities that we expect to meet our pricing and risk standards. We will seek to underwrite our portfolio of low to medium hazard risks with a view toward maintaining long-term underwriting profitability across market cycles.

Continue to Grow in Our Existing Markets. Since commencing operations in Nevada in 2000, we have expanded our operations to California, were able to establish important strategic distribution relationships with ADP and Wellpoint because of the Fremont transaction, entered seven other states and obtained licenses in six new states. We plan to continue to seek profitable growth in our existing markets by addressing the workers' compensation insurance needs of small businesses, which we believe represent a large and profitable market segment, and by entering into new strategic distribution agreements such as our recent agreement with E-chx. Small businesses generally grow faster than large businesses and, according to the United States Small Business Administration, 60% to 80% of new jobs over the past decade ending in 2005 were created by small businesses. In the states in which we operate, the workers' compensation market for small businesses is not highly concentrated, with a significant portion of premiums being written by numerous insurance companies with small individual market shares. We believe that our focus on workers' compensation insurance, our disciplined underwriting and risk selection, and our loss control and claims management expertise for small businesses position us to profitably increase our market share in our existing markets.

Enter New Markets Through Our Existing Distribution Relationships. Since commencing operations in Nevada in 2000, we have expanded our operations to California, established important strategic distribution relationships with ADP and Wellpoint, entered seven new states and obtained licenses in six other states. We intend to continue to selectively enter new markets, taking into account the adequacy of premium rates, market dynamics, the labor market, political and economic conditions and the regulatory environment. Our strategic distribution partnerships with ADP and Wellpoint have allowed us to access new customers and to write attractive business in an efficient manner. For example, we entered Illinois in the fourth quarter of 2006 and we intend to enter Florida in the first quarter of 2007 through ADP. Additionally, we will seek to leverage our existing independent agent and broker relationships to enter new states.



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Capitalize on the Flexibility of Our New Corporate Structure. This initial public offering is part of our conversion from a mutual insurance holding company owned by our Nevada policyholder members to a stock corporation owned by our public stockholders. We believe that our conversion to a public company will give us enhanced financial and strategic flexibility. This will allow us to consider acquisitions, joint ventures and other strategic transactions, as well

as new product offerings, which make strategic sense for our business while achieving our goal of profitable growth.

Manage Capital Prudently. We intend to manage our capital prudently relative to our overall risk exposure, establishing adequate loss reserves to protect against future adverse developments while seeking to grow profits and long-term stockholder value, maintain our financial strength, fund growth, invest in our infrastructure or return capital to stockholders, which may include share repurchases. We will target an optimal level of overall leverage to support our underwriting activities and are committed to maintaining our financial strength and ratings over the long term.

Leverage Infrastructure, Technology and Systems. We will continue to invest in our scalable, cost-effective infrastructure and our underwriting and claims processing technology and systems. We recently introduced a new highly automated underwriting system, which over time will replace three legacy underwriting systems. We anticipate that this new system will reduce transaction costs and support future profitable growth. In 2007, we expect to implement a new claims system designed to enhance our ability to support best-in-class claims processing.

The Conversion

On August 17, 2006, the board of directors of EIG, which we refer to in this prospectus as our board of directors, unanimously proposed, approved and adopted a plan of conversion under which EIG will convert from a mutual insurance holding company to a stock corporation. On October 3, 2006, our board of directors unanimously approved an amended and restated plan of conversion, which we refer to in this prospectus as the plan of conversion. This offering is being made in connection with the completion of the conversion, and each of the effectiveness of the conversion and the completion of this offering are conditioned upon the occurrence of the other.

Upon completion of the conversion, EIG will become a Nevada stock corporation and will change its name to ‘‘Employers Holdings, Inc.’’ and all of the membership interests of our policyholder members will be extinguished. In exchange, eligible members will receive shares of our common stock, cash or a combination of both. When the conversion and this offering are complete, EIG will be a public company and will continue to indirectly own 100% of the common stock of Employers Insurance Company of Nevada, or EICN, and our other operating subsidiaries.

Pursuant to Nevada law and the plan of reorganization that EICN adopted and amended in 2004 to reorganize into a mutual insurance holding company structure, the plan of conversion, including the amendments to EIG’s articles of incorporation contemplated thereby, must be approved by both the affirmative vote of a majority of EIG’s members, as of a record date fixed by EIG’s board of directors in accordance with EIG’s by-laws, and by the affirmative vote of not less than two-thirds of the eligible members voting in person or by proxy at the meeting of EIG’s members called to vote on the plan of conversion. Nevada law also requires that the plan of conversion be approved by the Nevada Commissioner of Insurance, by issuance of both an initial order following a public hearing, and a final order approving the application for conversion. Under the terms of the plan of conversion, the conversion will not become effective until we have obtained these approvals and the Nevada Commissioner of Insurance has issued a new certificate of authority to EICN. The articles of incorporation and by-laws of EIG will be amended and restated effective upon completion of the conversion in the form filed as exhibits to the registration statement of which this prospectus forms a part.

On August 22, 2006, we filed an application for conversion with the Nevada Commissioner of Insurance. The Nevada Commissioner of Insurance held a public hearing on the application for conversion on October 26, 2006 and issued an initial order approving the application for conversion on November 29, 2006, based upon, among other things, a determination that the plan of conversion is fair

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and equitable to EIG's eligible members. At a special meeting of its members on January 13, 2007, the plan of conversion, including the amended and restated articles of incorporation of EIG, was approved by the required votes of EIG's members. On January 13, 2007, the Nevada Commissioner of Insurance issued a final order approving the application for conversion.

Risks Relating to Our Business and this Offering

Investing in our shares of common stock involves substantial risk. In addition, the maintenance of our competitive strengths, the implementation of our strategy and our future results of operations and financial condition are subject to a number of risks and uncertainties. The factors that could adversely affect our actual results and performance, as well as the successful implementation of our strategy, are discussed under the headings ''Risk Factors'' and ''Forward-Looking Statements and Associated Risks'' and include, but are not limited to:

Uncertainty of Establishing Loss Reserves. We establish reserves for our losses and LAE based on estimates involving actuarial and statistical projections of the ultimate settlement and administration costs of claims on the policies we write. These reserves may be inadequate to cover our ultimate liability for losses and actual claims and claim expenses paid might exceed our reserves.

Downward Pressure on Premiums as a Result of Regulation. In 2005, 77.7% of our direct premiums written were generated in California, a state that has recently been through a cycle of substantial rate increases followed by equally substantial rate decreases. As a result of these pressures and various regulatory reforms, from September 2003 through January 1, 2007, we have reduced our rates in California by 60% and expect that we will further reduce our rates in the foreseeable future. Future rate regulations in California or any state in which we operate could impair our ability to operate profitably and ultimately have a material adverse effect on our financial condition and results of operations.

Geographic Concentration. Our written premiums are heavily concentrated in the western United States, particularly California and Nevada. Our revenues and profitability for the foreseeable future will be substantially impacted by prevailing regulatory, economic, demographic, competitive, weather and other conditions in these states.

Exposure to Natural and Man-Made Disasters. Our insurance operations expose us to claims arising out of unpredictable natural and other catastrophic events, as well as man-made disasters such as acts of terrorism. Claims arising from such events could reduce our earnings and cause substantial volatility in our results of operations for any fiscal quarter or year and adversely affect our financial condition. Additionally, under our excess of loss reinsurance treaty, or contract of reinsurance, our reinsurers' obligation to cover terrorism-related events is limited.

We Write Only a Single Line of Insurance. Because we offer only a single line of insurance, workers' compensation, we are at a competitive disadvantage to our competitors who offer a wide array of insurance products. Additionally, we are fully exposed to the cyclicality of the workers' compensation insurance market, which has been characterized in the past by periods of intense price competition due to excessive underwriting capacity.

Termination or Underperformance of Our Principal Strategic Distribution Relationships. Our relationships with ADP and Wellpoint are responsible for a substantial portion of our premiums written and our reliance on these relationships will increase as we enter new states. Our agreement with ADP is not exclusive, and ADP can terminate the agreement with us without cause upon 120 days' notice. Although our agreements with Wellpoint are exclusive, Wellpoint may terminate its agreements with us if we are not able to provide coverage through a carrier with an A.M. Best financial strength rating of B++ or better. Wellpoint may also terminate its agreements with us without cause upon 60 days' notice. The termination of either of these relationships would have a substantial impact on our business and results of operations, and we cannot assure you that we would be able to develop similar relationships with other

distribution partners on terms favorable to us.

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Changes in the Availability, Cost or Quality of Reinsurance Coverage. We may be unable to purchase reinsurance for our own account on commercially acceptable terms or to collect under any reinsurance we have purchased.

Constraints Related to Our Holding Company Structure. As a holding company, EIG has no direct operations. Dividends and other permitted distributions from insurance subsidiaries are expected to be EIG's sole source of funds to meet ongoing cash requirements. These payments are limited by regulations in the jurisdictions in which EIG's subsidiaries operate. If EIG's insurance subsidiaries are unable to pay dividends, EIG may have difficulty paying dividends on common stock and meeting holding company expenses.

Our Corporate Information

Our principal executive offices are located at 9790 Gateway Drive, Reno, Nevada 89521. Our telephone number is (888) 682-6671. Our internet address is www.eig.com. Information on our website does not constitute part of this prospectus. Our Nevada insurance subsidiary was organized in Nevada in 1999 and commenced operations in 2000. EIG was created in Nevada in April 2005 as a result of our reorganization into a mutual insurance holding company structure.

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The Offering

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| Common stock offered by us | 26,750,000 shares. |
| Common stock estimated to be outstanding immediately after the offering | 52,715,221 shares. |
| Use of proceeds | We estimate that our net proceeds from the sale of shares of common stock in the offering will be approximately $425.2 million, or $489.0 million if the underwriters exercise their over-allotment option in full as described under ''Underwriters,'' after deducting the underwriting discounts and commissions payable by us, and we estimate that the proceeds available to eligible members as cash consideration in the conversion, which equals those net proceeds less estimated conversion and offering expenses, will be $408.6 million, or $472.4 million if the underwriters exercise their over-allotment option in full. |

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| | The plan of conversion requires us to use all or a portion of the net proceeds (after deducting underwriting discounts and commissions) (1) first, to pay all fees and expenses incurred by us in connection with the conversion and this offering and all cash consideration payable to eligible members of EIG who are not eligible to receive our common stock in the conversion (which we refer to in this prospectus collectively as the ‘‘mandatory cash requirements’’); and (2) next, to pay the cash consideration payable to eligible members of EIG who elect to receive cash instead of our common stock (which we refer to in this prospectus as the ‘‘elective cash requirements’’). Based on the number of cash elections received from our members, and assuming that the underwriters do not exercise their over-allotment option, no net proceeds will remain after all of the foregoing amounts have been paid in full. The net proceeds of any exercise of the underwriters’ over-allotment option will be used first to fund any portion of the elective cash requirements that are not funded in full by the net proceeds of the offering before such exercise, and EIG may retain and use any remaining amounts from such exercise for working capital, payment of future dividends on the common stock, repurchases of shares of common stock and other general corporate purposes. |
| Dividend policy | Our board of directors has authorized the payment of a dividend of $0.06 per share of our common stock per quarter to our stockholders of record beginning in the second quarter of 2007. See ‘‘Dividend Policy.’’ Any determination to pay dividends will be at the discretion of our board of directors and will be dependent upon EICN’s payment of dividends and/or other statutorily permissible payments to us, our results of operations and cash flows, our financial position |





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| | and capital requirements, general business conditions, any legal, tax, regulatory and contractual restrictions on the payment of dividends (including those described under ‘‘Regulation—Financial, Dividend and Investment Restrictions’’), and any other factors our board of directors deems relevant. At September 30, 2006, EICN had positive unassigned surplus of $23.4 million and had the capability to pay a dividend to us in such amount without prior approval of the Nevada Commissioner of Insurance. On October 17, 2006 the Nevada Commissioner of |

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| | Insurance granted EICN permission to pay us up to an additional $55 million in one or more extraordinary dividends subsequent to the successful completion of this offering and before December 31, 2008, which dividends may be used by us to pay quarterly dividends to our stockholders. See ‘‘Dividend Policy’’ and ‘‘Regulation—Financial, Dividend and Investment Restrictions.’’ There can be no assurance that we will declare and pay any dividends. |
| New York Stock Exchange symbol | ‘‘EIG.’’ |

Except as otherwise indicated, this prospectus:

- assumes no exercise of the underwriters’ over-allotment option;
- assumes the completion of our conversion to a stock corporation from a mutual insurance holding company owned by our policyholder members, as described under ‘‘The Conversion’’;
- reflects the filing, prior to the closing of this offering, of EIG’s amended and restated articles of incorporation and the adoption of EIG’s amended and restated by-laws, implementing the provisions described under ‘‘Description of Capital Stock’’; and
- reflects that, based on the number of cash elections received from our members, we do not have an option to pay in cash a portion of the consideration to be paid to those eligible members who do not elect cash (as described under ‘‘The Conversion—Amount and Form of Consideration—Cash Consideration to Non-Electing Members’’) and therefore we will not issue additional shares of common stock to such members in the conversion in connection with any ‘‘top up’’ amount to which they could have become entitled under certain circumstances if we had such option and were to exercise it.

Trademarks and Copyrights

We own or have rights to trademarks, service marks and trade names that we use in conjunction with the operation of our business including, without limitation, the following: Employers Insurance Group®, Employers Insurance Company of Nevada®, Employers Compensation Insurance Company® and EMPLOYERS℠. Each trademark, service mark or trade name of any other company appearing in this prospectus belongs to its holder.

Workers’ Compensation Insurance Hazard Groups

The workers’ compensation insurance industry classifies risks into hazard groups defined by the National Council on Compensation Insurance, or NCCI, and based on severity, with employers in lower groups having lower cost claims. Until December 31, 2006, the NCCI defined four hazard groups. Effective January 1, 2007, the NCCI changed the number of hazard groups from four to seven. Since the financial information presented in this prospectus relates to periods prior to the adoption of the new hazard group structure by the NCCI, all references in this prospectus to hazard groups are to the four hazard groups as defined by the NCCI prior to January 1, 2007.



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Summary Historical Consolidated Financial and Other Data

The following summary historical consolidated financial data should be read in conjunction with ‘‘Management’s Discussion and Analysis of Financial Condition and Results of Operations’’ and the consolidated financial statements and related notes included elsewhere in this prospectus. The summary historical financial data as of September 30, 2006 and for the nine months ended September 30, 2005 and 2006, have been derived from our unaudited consolidated financial statements and related notes thereto included elsewhere in this prospectus, which include all adjustments, consisting of normal recurring adjustments, that management considers necessary for a fair presentation of our financial position and results of operations for the periods presented. The results for periods of less than a full year are not necessarily indicative of the results to be expected for any interim period or for a full year. The summary historical financial data as of December 31, 2004 and 2005 and for the years ended December 31, 2003, 2004 and 2005 have been derived from our audited consolidated financial statements and related notes thereto included elsewhere in this prospectus. The summary historical financial data as of December 31, 2003 have been derived from our audited consolidated financial statements and related notes thereto not included in this prospectus. The summary historical financial data as of and for the years ended December 31, 2001 and 2002 have been derived from our unaudited consolidated financial statements and related notes thereto not included in this prospectus. These historical results are not necessarily indicative of results to be expected in any future period.

The summary historical financial data reflects the ongoing impact of the LPT Agreement, a retroactive 100% quota share reinsurance agreement that our Nevada insurance subsidiary assumed on January 1, 2000 in connection with our assumption of the assets, liabilities and operations of the Fund, pursuant to legislation passed in the 1999 Nevada legislature. A quota share reinsurance agreement is a proportional or pro rata reinsurance treaty under which the same proportion is ceded on all cessions and the reinsurer assumes a set percentage of risk for the same percentage of the premium, minus an allowance for the ceding company’s expenses. Upon entry into the LPT Agreement, we recorded as a liability a deferred reinsurance gain which we amortize over the period during which underlying reinsured claims are paid. We record adjustments to the direct reserves subject to the LPT Agreement based on our periodic reevaluations of these reserves. Direct reserves are our estimates of future losses and LAE payments on policies written by our insurance subsidiaries before the effect of ceded reinsurance.



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| | Year Ended December 31, | | | | | Nine Months En September 30 | |
|---|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2005 | 2 |
| | (in thousands, except ratios) | | | | | | |
| Income Statement Data: | | | | | | | |
| Revenues: | | | | | | | |
| Net premiums earned | $126,368 | $180,116 | $298,208 | $410,302 | $438,250 | $331,066 | $30 |
| Net investment income | 47,421 | 36,889 | 26,297 | 42,201 | 54,416 | 39,520 | 4 |
| Realized (losses) gains on investments | (222) | (2,028) | 5,006 | 1,202 | (95) | (2,496) | |
| Other income | 2,372 | (6,442) | 1,602 | 2,950 | 3,915 | 2,929 | |
| Total revenues | 175,939 | 208,535 | 331,113 | 456,655 | 496,486 | 371,019 | 35 |
| Expenses: | | | | | | | |
| Losses and loss adjustment expenses | 69,670 | 113,776 | 118,123 | 229,219 | 211,688 | 208,246 | 9 |
| Commission expense | 15,964 | 16,919 | 56,310 | 55,369 | 46,872 | 36,859 | 3 |
| Underwriting and other operating expense | 37,462 | 44,345 | 56,738 | 65,492 | 69,934 | 47,726 | 5 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Total expenses | 123,096 | 175,040 | 231,171 | 350,080 | 328,494 | 292,831 | 19 |
| Net income before income taxes | 52,843 | 33,495 | 99,942 | 106,575 | 167,992 | 78,188 | 16 |
| Income taxes | 2,706 | 834 | 3,720 | 11,008 | 30,394 | 15,083 | 5 |
| Net income | $ 50,137 | $ 32,661 | $ 96,222 | $ 95,567 | $137,598 | $ 63,105 | $11 |
| Selected Operating Data: | | | | | | | |
| Gross premiums written[1] | $120,732 | $197,202 | $337,089 | $437,694 | $458,671 | $351,668 | $31 |
| Net premiums written[2] | 114,763 | 186,950 | 297,649 | 417,914 | 439,721 | 336,347 | 29 |
| Losses and LAE ratio[3] | 55.1% | 63.2% | 39.6% | 55.9% | 48.3% | 62.9% | |
| Commission expense ratio[4] | 12.6 | 9.4 | 18.9 | 13.5 | 10.7 | 11.1 | |
| Underwriting and other operating expense ratio[5] | 29.6 | 24.6 | 19.0 | 16.0 | 16.0 | 14.4 | |
| Combined ratio[6] | 97.3 | 97.2 | 77.5 | 85.4 | 75.0 | 88.4 | |
| Net income before impact of LPT Agreement[7][8][9] | $ 26,464 | $ 11,015 | $ 46,098 | $ 72,824 | $ 93,842 | $ 47,575 | $10 |

| | As of December 31, | | | | | As of |
|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | September 2006 |
| | (in thousands, except ratios) | | | | | |
| Balance Sheet Data: | | | | | | |
| Cash and cash equivalents | $ 182,955 | $ 283,351 | $ 166,213 | $ 60,414 | $ 61,083 | $ 65,9 |
| Total investments | 975,850 | 858,637 | 1,015,762 | 1,358,228 | 1,595,771 | 1,730,7 |
| Reinsurance recoverable on paid and unpaid losses | 1,352,225 | 1,315,240 | 1,243,085 | 1,206,612 | 1,151,166 | 1,116,3 |
| Total assets | 2,714,020 | 2,683,916 | 2,738,295 | 2,935,686 | 3,094,229 | 3,189,7 |
| Unpaid losses and loss adjustment expenses | 2,226,000 | 2,212,368 | 2,193,439 | 2,284,542 | 2,349,981 | 2,315,5 |
| Deferred reinsurance gain – LPT Agreement[7][8] | 600,679 | 579,033 | 528,909 | 506,166 | 462,409 | 447,7 |
| Total liabilities | 2,971,502 | 2,911,865 | 2,842,754 | 2,925,936 | 2,949,622 | 2,916,6 |
| Total (deficit) equity | (257,482) | (227,949) | (104,459) | 9,750 | 144,607 | 273,0 |
| Other Financial and Ratio Data: | | | | | | |
| Total equity including deferred reinsurance gain – LPT Agreement[7][8][10] | $ 343,197 | $ 351,084 | $ 424,450 | $ 515,916 | $ 607,016 | $ 720,8 |
| Total statutory surplus[11] | $ 209,797 | $ 224,234 | $ 338,656 | $ 430,676 | $ 530,612 | $ 625,8 |
| Net premiums written to total statutory surplus ratio[12] | 0.55x | 0.83x | 0.88x | 0.97x | 0.83x | |

(1) Gross premiums written is the sum of both direct premiums written and assumed premiums written before the effect of ceded reinsurance and the intercompany pooling agreement. Direct premiums written are the premiums on all policies our insurance subsidiaries have issued during the year. Assumed premiums written are premiums that our insurance subsidiaries have received from any authorized state-mandated pools and previous fronting facilities. Our previous fronting facilities involved the assumption by our insurance subsidiaries of insurance policies issued by other unaffiliated insurance companies. See Note 7 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus.

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(2)Net premiums written is the sum of direct premiums written and assumed premiums written less ceded premiums written. Ceded premiums written is the portion of direct premiums written that we cede to our reinsurers under our reinsurance contracts. See Note 7 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus.

(3)Losses and loss adjustment expenses, or LAE, ratio is the ratio (expressed as a percentage) of losses and LAE to net premiums earned. Net premiums earned is that portion of net premiums written equal to the expired portion of the time for which insurance protection was provided during the financial year and is recognized as revenue.

(4)Commission expense ratio is the ratio (expressed as a percentage) of commission expense to net premiums earned.

(5)Underwriting and other operating expense ratio is the ratio (expressed as a percentage) of underwriting and other operating expense to net premiums earned.

(6)Combined ratio is the sum of the losses and LAE ratio, the commission expense ratio and the underwriting and other operating expense ratio.

(7)In connection with our January 1, 2000 assumption of the assets, liabilities and operations of the Fund, our Nevada insurance subsidiary assumed the Fund's rights and obligations associated with the LPT Agreement, a retroactive 100% quota share reinsurance agreement with third party reinsurers, which substantially reduced exposure to losses for pre-July 1, 1995 Nevada insured risks. Pursuant to the LPT Agreement, the Fund initially ceded $1.525 billion in liabilities for incurred but unpaid losses and LAE, which represented substantially all of the Fund's outstanding losses as of June 30, 1999 for claims with original dates of injury prior to July 1, 1995.

(8)Deferred reinsurance gain—LPT Agreement reflects the unamortized gain from our LPT Agreement. Under U.S. generally accepted accounting principles, or GAAP, this gain is deferred and is being amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE. We periodically reevaluate the remaining direct reserves subject to the LPT Agreement. Our reevaluation results in corresponding adjustments, if needed, to reserves, ceded reserves, reinsurance recoverables and the deferred reinsurance gain, with the net effect being an increase or decrease, as the case may be, to net income.

(9)We define net income before impact of LPT Agreement as net income less (i) amortization of deferred reinsurance gain—LPT Agreement and (ii) adjustment to LPT Agreement ceded reserves. Net income before impact of LPT Agreement is not a measurement of financial performance under GAAP and should not be considered in isolation or as an alternative to net income before income taxes and net income or any other measure of performance derived in accordance with GAAP.

We present net income before impact of LPT Agreement because we believe that it is an important supplemental measure of operating performance to be used by analysts, investors and other interested parties in evaluating us. The LPT Agreement was a non-recurring transaction which does not result in ongoing cash benefits and, consequently, we believe this presentation is useful in providing a meaningful understanding of our operating performance. In addition, we believe this non-GAAP measure, as we have defined it, is helpful to our management in identifying trends in our performance because the excluded item has limited significance in our current and ongoing operations.

The table below shows the reconciliation of net income to net income before impact of LPT Agreement for the periods presented:

| | Year Ended December 31, | | | | | Nine Months Ended September 30, | |
|---|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2005 | 2006 |

| | (in thousands) | | | | | | |
|---|---|---|---|---|---|---|---|
| Net income | $50,137 | $32,661 | $96,222 | $95,567 | $137,598 | $63,105 | $116,488 |
| Less: Impact of LPT Agreement: | | | | | | | |
| Amortization of deferred reinsurance gain – LPT Agreement | 24,262 | 21,690 | 19,015 | 20,296 | 16,891 | 15,530 | 14,614 |
| Adjustments to LPT Agreement ceded reserves[(a)] | (589) | (44) | 31,109 | 2,447 | 26,865 | — | — |
| Net income before impact of LPT Agreement | $26,464 | $11,015 | $46,098 | $72,824 | $ 93,842 | $47,575 | $101,874 |

(a) Any adjustment to the estimated direct reserves ceded under the LPT Agreement is reflected in losses and LAE for the period during which the adjustment is determined, with a corresponding increase or decrease in net income in the period. There is a corresponding change to the reinsurance recoverables on unpaid losses as well as the deferred reinsurance gain. A cumulative adjustment to the amortization of the deferred gain is also then recognized in earnings so that the deferred reinsurance gain reflects the balance that would have existed had the revised reserves been recognized at the inception of the LPT Agreement. See Note 2 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus. Losses and LAE for the nine months ended September 30, 2005 and 2006 did not include any adjustment to LPT Agreement ceded reserves, as our reevaluation of the direct reserves subject to the LPT Agreement did not result in an adjustment for the nine months ended September 30, 2005 and 2006.

(10) We define total equity including deferred reinsurance gain—LPT Agreement as total equity plus deferred reinsurance gain— LPT Agreement. Total equity including deferred reinsurance gain—LPT Agreement is not a measurement of financial position under GAAP and should not be considered in isolation or as an alternative to total equity or any other measure of financial health derived in accordance with GAAP. We present total equity including deferred reinsurance gain—LPT Agreement because we believe that it is an important supplemental measure of financial position to be used by analysts, investors and other interested parties in evaluating us. The



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LPT Agreement was a non-recurring transaction and the treatment of the deferred gain does not result in ongoing cash benefits and consequently we believe this presentation is useful in providing a meaningful understanding of our financial position.

The table below shows the reconciliation of total equity to total equity including deferred reinsurance gain—LPT Agreement for the periods presented:

| | As of December 31, | | | | | As of |
|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | September 30, |
| | (in thousands) | | | | | |
| Total (deficit) equity | $(257,482) | $(227,949) | $(104,459) | $ 9,750 | $144,607 | $270,055 |
| Deferred reinsurance gain – LPT Agreement | 600,679 | 579,033 | 528,909 | 506,166 | 462,409 | 447,795 |
| Total equity including deferred reinsurance gain – LPT Agreement | $ 343,197 | $ 351,084 | $ 424,450 | $515,916 | $607,016 | $720,850 |

(11) Total statutory surplus represents the total consolidated surplus of EICN, which includes its wholly-owned subsidiary, Employers Compensation Insurance Company, or ECIC, our insurance

subsidiaries, prepared in accordance with the accounting practices of the National Association of Insurance Commissioners, or NAIC, as adopted by Nevada or California, as the case may be. See Note 9 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus.

(12) Net premiums written to total statutory surplus ratio is the ratio of our insurance subsidiaries' annual net premiums written to total statutory surplus.



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## RISK FACTORS

Investing in our common stock involves risks. You should carefully consider the following risk factors and other information in this prospectus before purchasing our common stock. The trading price of our common stock may decline due to any of these risks, and you could lose all or part of your investment.

### Risks Related to Our Business

**Our liability for losses and loss adjustment expenses is based on estimates and may be inadequate to cover our actual losses and expenses.**

We must establish and maintain reserves for our estimated losses and loss adjustment expenses. We establish loss reserves in our financial statements that represent an estimate of amounts needed to pay and administer claims with respect to insured claims that have occurred, including claims that have occurred but have not yet been reported to us. Loss reserves are estimates of the ultimate cost of individual claims based on actuarial estimation techniques and are inherently uncertain. Judgment is required in applying actuarial techniques to determine the relevance of historical payment and claim settlement patterns under current facts and circumstances. In states other than Nevada, we have a short operating history and must rely on a combination of industry experience and our specific experience to establish our best estimate of losses and LAE reserves. The interpretation of historical data can be impacted by external forces, principally legislative changes, medical cost inflation, economic fluctuations and legal trends. In California, there have been significant legislative changes affecting workers' compensation benefits to injured workers and claims administration, and we are observing changes in claim costs and claim payment patterns. We review our loss reserves each quarter. We may adjust our reserves based on the results of these reviews and these adjustments could be significant. If we change our estimates, these changes are reflected in our results of operations during the period in which they are made.

Loss reserves are estimates at a given point in time of our ultimate liability for cost of claims and of the cost of managing those claims, and are inherently uncertain. It is likely that the ultimate liability will differ from our estimates, perhaps significantly. Such estimates are not precise in that, among other things, they are based on predictions of future claim emergence and payment patterns and estimates of future trends in claim frequency and claim cost. These estimates assume that the claim emergence and payment patterns, claim inflation and claim frequency trend assumptions implicitly built into estimates will continue into the future. Unexpected changes in claim cost inflation can occur through changes in general inflationary trends, changes in medical technology and procedures, changes in wage levels and general economic conditions and changes in legal theories of compensability of injured workers and their dependents. Furthermore, future costs can be influenced by changes in the workers' compensation statutory benefit structure and in benefit administration and delivery. It often becomes necessary to refine and adjust the estimates of liability on a claim either upward or downward. Even after such adjustments, ultimate liability may exceed or be less than the revised estimates.

Workers' compensation benefits are often paid over a long period of time. For example, in addition to medical expenses, an injured worker may receive payments for lost income associated with total or partial disability, whether temporary or permanent (i.e., the disability is expected to continue until normal retirement age or death, whichever comes first). We may also be required to make payments, often over a period of many years, to surviving spouses and children of workers who are killed on the job or may be required to make relatively small payments on claims that have already been closed (which we refer to as reopenings). In addition, there are no policy limits on our liability for workers' compensation claims as there are for other forms of insurance. Therefore, estimating reserves for workers' compensation claims may be more uncertain than estimating reserves for other lines of insurance with shorter or more definite periods between occurrence of the claim and final determination of the ultimate loss and with policy limits on liability for claim amounts. Accordingly, our reserves may prove to be inadequate to cover our actual losses.

Our estimates of incurred losses and LAE attributable to insured events of prior years have decreased for past accident years because actual losses and LAE paid and current projections of unpaid losses and LAE were less than we originally anticipated. We refer to such decreases as favorable



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developments. The reductions in reserves were $81.7 million, $78.1 million, $37.6 million, $69.2 million, $11.5 million and $38.7 million for the nine months ended September 30, 2006 and the years ended December 31, 2005, 2004, 2003, 2002 and 2001, respectively. Estimates of net incurred losses and LAE are established by management utilizing actuarial indications based upon our historical and industry experience regarding claim emergence and claim payment patterns, and regarding medical cost inflation and claim cost trends, adjusted for future anticipated changes in claims-related and economic trends, as well as regulatory and legislative changes, to establish our best estimate of the losses and LAE reserves. The decrease in the prior year reserves was primarily the result of actual paid losses being less than expected, and revised assumptions used in projection of future losses and LAE payments based on more current information about the impact of certain changes, such as legislative changes, which was not available at the time the reserves were originally established. While we have had favorable developments over the past five years, the magnitude of these developments illustrates the inherent uncertainty in our liability for losses and loss adjustment expenses, and we believe that favorable or unfavorable developments of similar magnitude, or greater, could occur in the future.

State workers' compensation insurance regulations in California and other states where we operate have caused and may continue to cause downward pressure on the premiums we charge.

Our pricing decisions need to take into account the workers' compensation insurance regulatory regime of each state in which we conduct operations, such as regimes that address the rates that industry participants in that state may or should charge for policies. In 2005, 77.7% of our direct premiums written were generated in California. Accordingly, we are particularly affected by regulation in California.

California has recently been through a cycle of substantial rate increases, followed by equally substantial rate decreases. Until 1995, insurance companies were subject to minimum rate regulation in California. The state had established a minimum rate floor, and workers' compensation insurers could not charge rates lower than that floor. In 1995, California eliminated its minimum rate regulation and allowed open price competition among workers' compensation insurers. One of the results of this was intense pricing competition among insurance companies, with many lowering rates to levels that ultimately resulted in more than 20 insolvencies. By 2002, rates in California had increased significantly, driven by an expensive benefit delivery system, claims which resulted in higher than normal

litigation and a lack of insurance capital within the state. Since 2002, three key pieces of workers' compensation regulation reform have been enacted which reformed medical determinations of injuries or illness, established medical fee schedules, allowed for the use of medical provider panels, modified benefit levels, changed the proof needed to file claims, and reformed many additional areas of the workers' compensation benefits and delivery system. Workers' compensation insurers in California responded to these reforms by reducing their rates. For example, we have reduced our rates in California by 60% since September 2003 through January 1, 2007 and expect that we will further reduce our rates in the foreseeable future. These reductions in rates in California are in response to the legislative reforms which have reduced claim costs in California. Several attempts have been made to institute additional forms of rate regulation in California; however, none of those attempts have been enacted by the legislature as of October 31, 2006. The passage of any form of rate regulation in California could impair our ability to operate profitably in California, and any such impairment could have a material adverse effect on our financial condition and results of operations. Additionally, although the California Insurance Commissioner does not set premium rates, he does adopt and publish advisory ''pure premium'' rates which are rates that would cover expected losses but do not contain an element to cover operating expenses or profit. He recommended a 16.4% reduction in workers' compensation ''pure premium'' rates starting in July 2006. In early November 2006, the California Insurance Commissioner recommended that ''pure premium'' rates be reduced by an additional 9.5% for policies written on or after January 1, 2007. Our California rates continue to be based upon our actuarial analysis of current and anticipated cost trends, and we have determined that our California rates effective on January 1, 2007 will include the 9.5% reduction recommended by the California Insurance Commissioner.

In early January 2007, the governor of California stated his intent to make significant changes to the health care system in California. Under the proposed plan, companies with 10 or more employees would be required to pay at least 4% of payroll for health insurance or to pay that amount into a general pool. Companies with fewer than 10 employees would be exempt but would still be required to pay an annual fee to help the state of California provide employee health coverage. Insurers would also be required to



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offer incentives to insured employees or premium reductions to employers as rewards to workers who stop smoking or take similar steps to improve their health. In light of the preliminary and uncertain status of the proposal, we are unable to predict the outcome of these changes on our financial condition or results of operations.

Certain states have adopted an ''administered pricing'' regime, under which rate competition is generally not permitted. Of the states in which we currently operate, only Idaho has implemented such regulation. However, we are exposed to the risk that other states in which we operate will adopt, or that new states which we intend to enter have implemented, administered pricing regimes. Such a regime could prevent us from appropriately pricing our insurance policies in those states, exposing us to the possibility of losses over and above the premiums we are able to collect. Florida, which we intend to enter through ADP in the first quarter of 2007, currently has administered pricing.

Due to the existence of rate regulation, and the possibility of adverse changes in such regulations, in the states in which we operate and new states that we enter, we cannot assure you that our premium rates will ultimately be adequate for the purposes of covering the claim payments, losses and LAE and company overhead or, in the case of states without administered pricing, that our competitors in such states will not set their premium rates at lower rates. In such event, we may be unable to compete effectively and our business, financial condition and results of operations could be materially adversely affected.

If we fail to price our insurance policies appropriately, our business competitiveness, financial condition or results of operations could be materially adversely affected.

The premiums we charge are established when coverage is bound. Premiums are based on the particular class of business and our estimates of expected losses and LAE and other expenses related to the policies we underwrite. We analyze many factors when pricing a policy, including the policyholder's prior loss history and industry classification. Inaccurate information regarding a policyholder's past claims experience puts us at risk for mispricing our policies. For example, when initiating coverage on a policyholder, we must rely on the information provided by the policyholder or the policyholder's previous insurer(s) to properly estimate future claims expense. If the claims information is not accurately stated, we may underprice our policies by using claims estimates that are too low. As a result, our business, financial condition and results of operations could be materially adversely affected. In order to set premium rates accurately, we must utilize an appropriate pricing model which correctly assesses risks based on their individual characteristics and takes into account actual and projected industry characteristics. We are in the process of implementing our E ACCESS automated underwriting system. E ACCESS and its ability to set premium rates accurately are subject to a number of risks and uncertainties, including technical problems, insufficient or unreliable data, uncertainties generally inherent in estimates and assumptions and industry factors such as the costs of ongoing medical treatment and unanticipated court decisions, legislation or regulatory action. Consequently, we could set our premium rates too low, which would negatively affect our results of operations and our profitability, or we could set our premium rates too high, which could reduce our competitiveness and lead to lower revenues.

Our geographic concentration in California and Nevada ties our performance to the business, economic, demographic and regulatory conditions in those states. Any deterioration in the conditions in those states could materially adversely affect our financial condition and results of operations.

Our business is concentrated in California, in which we generated 72.7% of our direct premiums written for the nine months ended September 30, 2006, and Nevada, in which we generated 20.6% of our direct premiums written for the nine months ended September 30, 2006. Accordingly, unfavorable business, economic, demographic, competitive or regulatory conditions in those states could negatively impact our business. We focus on select small businesses engaged in low to medium hazard industries. If the business or economic conditions in either California or Nevada deteriorate, the departure or insolvency of a significant number of small businesses from one or both of those states could have a material adverse effect on our financial condition or results of operations. Similarly, if the pool of workers declines in those states due to demographic trends, our financial condition and results of operations would be adversely affected. In addition, many California and Nevada businesses are dependent on tourism revenues, which are, in turn, dependent on a robust economy. Any downturn in general economic



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conditions, either nationally or in one or both of those states, or any other event that causes a deterioration in tourism in either state, could adversely impact small businesses such as restaurants that we have targeted as customers. We may be exposed to greater risks than those faced by insurance companies that conduct business over a greater geographic area. For example, our geographic concentration could subject us to pricing pressure as a result of market or regulatory forces. We have experienced such pressure in California in the past. For example, our premiums in force per policy in California as of September 30, 2006 have declined by approximately 26% since the same time in 2005, principally as a result of rate changes. See ''—State workers' compensation insurance regulations in California and other states where we operate have caused and may continue to cause downward pressure on the premiums we charge.'' We cannot assure you that we will not be subject to such pressure in California, or in any of our markets, in the future.

Acts of terrorism and catastrophes could expose us to potentially substantial losses and, accordingly, could materially adversely impact our financial condition and results of operations.

Under our workers' compensation policies and applicable laws in the states in which we operate, we are required to provide workers' compensation benefits for losses arising from acts of terrorism. The impact of any terrorist act is unpredictable, and the ultimate impact on us would depend upon the nature, extent, location and timing of such an act. We would be particularly adversely affected by a terrorist act in California or Nevada, most notably a terrorist act affecting any metropolitan area where our policyholders have a large concentration of workers. Notwithstanding the protection provided by the reinsurance we have purchased and any protection provided by the Terrorism Risk Insurance Extension Act of 2005, or the Terrorism Risk Act, the risk of severe losses to us from acts of terrorism has not been eliminated because our excess of loss reinsurance treaty program contains various sub-limits and exclusions limiting our reinsurers' obligation to cover losses caused by acts of terrorism. Excess of loss reinsurance is a form of reinsurance where the reinsurer pays all or a specified percentage of loss caused by a particular occurrence or event in excess of a fixed amount, up to a stipulated limit. Our excess of loss reinsurance treaties do not protect against nuclear, biological, chemical or radiological events. If such an event were to impact one or more of the employers we insure, we would be entirely responsible for any workers' compensation claims arising out of such event, subject to the terms of the Terrorism Risk Act, and could suffer substantial losses as a result. Under the Terrorism Risk Act, federal protection is provided to the insurance industry for events that result in an industry loss of at least $100 million in 2007. In the event of a qualifying industry loss (which must occur out of an act of terrorism certified as such by the Secretary of the Treasury), each insurance company is responsible for a deductible of 20% of direct earned premiums in the previous year, with the federal government responsible for reimbursing each company for 85% of the insurer's loss. Payouts to individual companies are limited, with the industry responsible for paying the lesser of $27.5 billion in 2007 or the aggregate amount of all insured losses, subject to a maximum aggregate federal payment of $100 billion. The Terrorism Risk Act is scheduled to expire on December 31, 2007 and may not be renewed, or if it is renewed, it may provide reduced protection against the financial impact of acts of terrorism. Accordingly, events may not be covered by, or may result in losses exceeding the capacity of, our reinsurance protection and any protection offered by the Terrorism Risk Act or any successor legislation. Thus, any acts of terrorism could expose us to potentially substantial losses and, accordingly, could materially adversely affect our financial condition and results of operations.

Our operations also expose us to claims arising out of catastrophes because we may be required to pay benefits to workers who are injured in the workplace as a result of a catastrophe. Catastrophes can be caused by various unpredictable events, including earthquakes, volcanic eruptions, hurricanes, windstorms, hailstorms, severe winter weather, floods, fires, tornadoes, explosions and other natural or man-made disasters. To date, we have not experienced catastrophic losses arising from any of these types of events. Any catastrophe occurring in the states in which we operate could expose us to potentially substantial losses and, accordingly, could have a material adverse effect on our financial condition and results of operations. The geographic concentration of our business in Nevada and California, known to be particularly prone to earthquakes, subjects us to increased exposure to claims arising out of such a catastrophic event.



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The fact that we write only a single line of insurance may leave us at a competitive disadvantage, and subjects our financial condition and results of operations to the cyclical nature of the workers' compensation insurance market.

We face a competitive disadvantage due to the fact that we only offer a single line of insurance. Some of our competitors have additional competitive leverage because of the wide array of insurance products that they offer. For example, a business may find it more efficient or less expensive to purchase multiple lines of commercial insurance coverage from a single carrier. Because we do not offer a range of insurance products and sell only workers' compensation insurance, we may lose potential customers to larger competitors who do offer a selection of insurance products.

The property and casualty insurance industry is cyclical in nature, and is characterized by periods of so-called ''soft'' market conditions in which premium rates are stable or falling, insurance is readily available and insurers' profits decline, and by periods of so-called ''hard'' market conditions, in which rates rise, coverage may be more difficult to find and insurers' profits increase. According to the Insurance Information Institute, since 1970, the property and casualty insurance industry experienced hard market conditions from 1975 to 1978, 1984 to 1987 and 2001 to 2004. Although the financial performance of an individual insurance company is dependent on its own specific business characteristics, the profitability of most workers' compensation insurance companies generally tends to follow this cyclical market pattern. Because we only offer workers' compensation insurance, our financial condition and operations are subject to this cyclical pattern, and we have no ability to change emphasis to another line of insurance. For example, during a period when there is excess underwriting capacity in the workers' compensation market and, therefore, lower profitability, we are unable to shift our focus to another line of insurance which is at a different stage of the insurance cycle and, thus, our financial condition and results of operations may be materially adversely affected. The California market in particular is transitioning from a period of capacity shortage to a period of capacity adequacy. This results in lower rate levels and smaller profit margins.

During the period from 1994 to 2001, we believe that rising loss costs, despite declines in the frequency of losses, severely eroded underwriting profitability in the workers' compensation insurance industry. According to the Insurance Information Institute, the workers' compensation industry's accident year combined ratios rose from 97% in 1994 to a high of 138% in 1999. We believe that rising loss costs and low investment returns in recent years have led to poor operating results and have caused some workers' compensation insurers to suffer severe capital impairment. Only recently during 2005 and in 2006 have we seen insurers begin to increase their capacity in order to allow the underwriting of additional premium in California, our largest market. Because this cyclicality is due in large part to the actions of our competitors and general economic factors, we cannot predict the timing or duration of changes in the market cycle. We have experienced significant increased price competition in our target markets since 2003. This cyclical pattern has in the past and could in the future adversely affect our financial condition and results of operations.

If our agreements with our principal strategic distribution partners are terminated or we fail to maintain good relationships with them, our revenues may decline materially and our results of operations may be materially adversely affected. We are also subject to credit risk with respect to our strategic distribution partners.

We have agreements with two principal strategic distribution partners, ADP and Wellpoint, to market and service our insurance products through their sales forces and insurance agencies. For the nine months ended September 30, 2006, we generated $32.9 million of gross premiums written through ADP and $49.1 million of gross premiums written through Wellpoint. The gross premiums written for ADP and Wellpoint were 10.6% and 15.8% of total gross premiums written during the nine months ended September 30, 2006, respectively. Our agreement with ADP is not exclusive, and ADP may terminate the agreement without cause upon 120 days' notice. Although our distribution agreements with Wellpoint are exclusive, Wellpoint may terminate its agreements with us if the rating of our insurance subsidiary ECIC were to be downgraded and we are not able to provide coverage through a carrier with an A.M. Best financial strength rating of B++ or better. Wellpoint may also terminate its agreements with us without cause upon 60 days' notice. The termination of any of these agreements, our failure to maintain good

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relationships with our principal strategic distribution partners or their failure to successfully market our products may materially reduce our revenues and have a material adverse effect on our results of operations if we are unable to replace the principal strategic distribution partners with other distributors that produce comparable premiums. In addition, we are subject to the risk that our principal strategic distribution partners may face financial difficulties, reputational issues or problems with respect to their own products and services, which may lead to decreased sales of our products and services. Moreover, if either of our principal strategic distribution partners consolidates or aligns itself with another company or changes its products that are currently offered with our workers' compensation insurance product, we may lose business or suffer decreased revenues.

We are also subject to credit risk with respect to ADP and Wellpoint, as they collect premiums that are due to us for the workers' compensation products that are marketed together with their own products. ADP and Wellpoint are obligated on a monthly basis to pass on premiums that they collect on our behalf. Any failure to remit such premiums to us or to remit such amounts on a timely basis could have an adverse effect on our results of operations.

If we do not maintain good relationships with independent insurance agents and brokers, they may sell our competitors' products rather than ours and our revenues or profitability may decline.

We market and sell our insurance products primarily through independent, non-exclusive insurance agents and brokers. These agents and brokers are not obligated to promote our products and can and do sell our competitors' products. We must offer workers' compensation insurance products and services that meet the requirements of these agents and their customers. We must also provide competitive commissions to these agents and brokers. Our business model depends upon an extensive network of local and regional agents and brokers distributed throughout the states in which we do business. We need to maintain good relationships with the agents and brokers with which we contract to sell our products. If we do not, these agents and brokers may sell our competitors' products instead of ours or may direct less desirable risks to us, and our revenues or profitability may decline. In addition, these agents and brokers may find it easier to promote the broader range of programs of some of our competitors than to promote our single-line workers' compensation insurance products. The loss of a number of our independent agents and brokers or the failure of these agents to successfully market our products may reduce our revenues and our profitability if we are unable to replace them with agents and brokers that produce comparable premiums.

If we are unable to execute our strategic plan and successfully enter new states, we may not be able to grow, and our financial condition and results of operations could be adversely affected.

One of our strategies is to enter new states. For example, we entered Illinois in the fourth quarter of 2006 and we intend to enter Florida in the first quarter of 2007 through ADP. Additionally, our lack of experience in these new states and the relative speed with which we will be entering them means that this strategy is subject to various risks, including risks associated with our ability to:

- comply with applicable laws and regulations in those new states;
- obtain accurate data relating to the workers' compensation industry and competitive environment in those new states;
- attract and retain qualified personnel for expanded operations;
- identify, recruit and integrate new independent agents, brokers and other distribution partners; and
- augment our internal monitoring and control systems as we expand our business.

Any of these risks, as well as risks that are currently unknown to us or adverse developments in the regulatory or market conditions in any of the new states that we enter, could cause us to fail to grow and could adversely affect our financial condition and results of operations.



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A downgrade in our financial strength rating could reduce the amount of business we are able to write or result in the termination of our agreements with ADP or Wellpoint.

Rating agencies rate insurance companies based on financial strength as an indication of an ability to pay claims. Our insurance subsidiaries are currently assigned a group letter rating of ''A−'' (Excellent), with a ''positive'' financial outlook, from A.M. Best, which is the rating agency that we believe has the most influence on our business. The ''A−'' (Excellent) rating is the fourth highest of 16 ratings and is the lowest rating within the category based on modifiers (i.e., ''A'' and ''A−'' are ''Excellent''). This rating is assigned to companies that, in the opinion of A.M. Best, have demonstrated an excellent overall performance when compared to industry standards. A.M. Best considers ''A−'' rated companies to have an excellent ability to meet their ongoing obligations to policyholders. In addition to A.M. Best ratings (which range from A++ to D for companies not under supervision or liquidation), companies are assigned a rating outlook that indicates the potential direction of a company's rating for an intermediate period, generally defined as the next twelve to 36 months. A rating outlook of ''positive'' indicates that a company's financial/market trends are favorable, relative to its current rating level and, if continued, the company has a good possibility of having its rating upgraded. This rating does not refer to our ability to meet non-insurance obligations and is not a recommendation to purchase or discontinue any policy or contract issued by us or to buy, hold or sell our securities.

The financial strength ratings of A.M. Best and other rating agencies are subject to periodic review using, among other things, proprietary capital adequacy models, and are subject to revision or withdrawal at any time. Insurance financial strength ratings are directed toward the concerns of policyholders and insurance agents and are not intended for the protection of investors or as a recommendation to buy, hold or sell securities. Although the policies that we have issued generally do not provide that policyholders may terminate such policies if the ratings of our insurance subsidiaries fall below a certain level, as a practical matter some of our policyholders may conduct businesses that require them to purchase workers' compensation insurance from insurers that are rated A− or better by A.M. Best. Additionally, our insurance agents and brokers may move their business to our competitors if our rating is downgraded. Therefore, any downgrade in the financial strength rating of our insurance subsidiaries would materially impair our ability to continue to write policies for these policyholders. We do not know how many of our policyholders have businesses that impose such ratings requirements on the purchase of workers' compensation insurance. Our competitive position relative to other companies is determined in part by our financial strength rating.

Our strategic distribution partner, Wellpoint, requires that we provide workers compensation coverage through a carrier rated B++ or better by A.M. Best. We currently provide this coverage through our subsidiary ECIC. Our inability to provide such coverage could cause a reduction in the number of policies we write, would adversely impact our relationships with our strategic distribution partners and could have a material adverse effect on our results of operations and our financial position. If ECIC's rating were to be downgraded and we were not able to enter an agreement to provide coverage through a carrier rated B++ or better by A.M. Best, Wellpoint may terminate its distribution agreements with us. We cannot assure you that we would be able to enter such an agreement if our rating were downgraded. The termination of our relationship with either ADP or Wellpoint would have a material adverse effect on our results of operations if we are unable to replace them with other distributors that produce comparable premiums.

If we are unable to obtain reinsurance, our ability to write new policies and to renew existing policies would be adversely affected and our financial condition and results of operations could be materially adversely affected.

Like other insurers, we manage our risk by buying reinsurance. Reinsurance is an arrangement in which an insurance company, called the ceding company, transfers a portion of insurance risk under policies it has written to another insurance company, called the reinsurer, and pays the reinsurer a portion of the premiums relating to those policies. Conversely, the reinsurer receives or assumes reinsurance from the ceding company. We currently purchase excess of loss reinsurance. We purchase reinsurance to cover larger individual losses and aggregate catastrophic losses from natural perils and terrorism. For the treaty, or contract, year beginning July 1, 2006, we have purchased reinsurance up to $175 million in excess of



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our $4 million net retention to protect against natural perils and acts of terrorism, excluding nuclear, biological, chemical and radiological events. Our retention is the amount of loss from a single occurrence or event which we must pay prior to the attachment of our excess of loss reinsurance. This means we have reinsurance for covered losses we suffer between $4 million and $175 million. This $175 million in reinsurance protection, in excess of our $4 million net retention, is subject to certain limitations, including (i) the aggregate reinsurance for covered losses between $4 million and $10 million is limited to $18 million, and (ii) the maximum reinsurance recoverable for any single person for losses between $10 million and $175 million is $7.5 million. Our current reinsurance treaty applies to all loss occurrences during and on policies which are in force between 12:01 a.m. July 1, 2006 through 12:01 a.m. July 1, 2007. We have the ability to extend the term of the treaty to continue to apply to policies which are in force at the expiration of the treaty generally for a period of 12 months, but we cannot assure you that our reinsurers will permit such an extension or that we can obtain such an extension on favorable terms. Covered losses which occur prior to expiration or cancellation of the treaty continue to be obligations of the reinsurer and subject to the other conditions in the agreement. We are responsible for these losses if the reinsurer cannot or refuses to pay.

The treaty includes certain exclusions for which our reinsurers are not liable for losses, including but not limited to, losses arising from the following: war, strikes or civil commotion; nuclear incidents other than incidental or ordinary industrial or educational or medical pursuits; underground mining except where incidental; oil and gas drilling, refining and manufacturing; manufacturing, storage and transportation of fireworks or other explosive substances or devices; asbestos abatement, manufacturing or distribution; excess policies attaching excess of a self-insured retention or a deductible greater than $25,000; and commercial airlines personnel. The reinsurance coverage includes coverage for acts of terrorism other than losses directly or indirectly caused by, contributed to, resulting from, or arising out of or in connection with nuclear, radiological, biological or chemical pollution, contamination or explosion. Any loss we suffer that is not covered by reinsurance could expose us to substantial losses.

We review and negotiate our reinsurance coverage annually. Our current treaty has a total of 24 subscribing reinsurers and, at September 30, 2006, Lloyds Syndicate #2020 WEL, Aspen Insurance UK Limited, American Reinsurance Company and Hannover Reuckversicherung-AG individually reinsured 32.0%, 17.5%, 15.0% and 15.0%, respectively, of the first layer of reinsurance ($6 million in excess of the first $4 million in losses). In addition, Endurance Specialty Insurance Ltd. and Aspen Insurance UK Limited reinsured 14.0% and 11.2%, respectively, of our total reinsurance limit ($175 million in excess of the first $4 million in losses) for a total of 25.2% of our total limit. The availability, amount and cost of reinsurance are subject to market conditions and to our loss experience. We cannot be certain that our reinsurance agreements will be renewed or replaced prior to their expiration upon terms satisfactory to us. If we are unable to renew or replace our reinsurance agreements upon terms satisfactory to us, our

net liability on individual risks would increase and we would have greater exposure to catastrophic losses. If this were to occur, our underwriting results would be subject to greater variability and our underwriting capacity would be reduced. These consequences could materially adversely affect our financial condition and results of operations.

We are subject to credit risk with respect to our reinsurers, and they may also refuse to pay or may delay payment of losses we cede to them.

Although we purchase reinsurance to manage our risk and exposure to losses, we continue to have direct obligations under the policies we write. We remain liable to our policyholders, even if we are unable to recover from our reinsurers what we believe we are entitled to receive under our reinsurance contracts. Reinsurers might refuse or fail to pay losses that we cede to them, or they might delay payment. For example, we had to replace one of the original reinsurers under the LPT Agreement when its A.M. Best rating dropped below the mandatory level. See ‘‘—Our assumption of the assets, liabilities and operations of the Fund covered all losses incurred by the Fund prior to January 1, 2000, pursuant to legislation passed in the 1999 Nevada legislature. We only obtained reinsurance covering the losses incurred prior to July 1, 1995, and we could be liable for all of those losses if the coverage provided by the LPT Agreement proves inadequate or we fail to collect from the reinsurers party to such transaction.’’ Since we exclusively write workers’ compensation insurance, with claims that may be paid out over a long period of time, the creditworthiness of our reinsurers may change before we can recover amounts to which we are entitled.



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Recent natural disasters, such as Hurricanes Katrina, Rita and Wilma, have caused unprecedented insured property losses, a significant portion of which will be borne by reinsurers. If a reinsurer is active in both the property and in the workers’ compensation insurance markets, its ability to perform its obligations in the latter market may be adversely affected by events unrelated to workers’ compensation insurance losses.

At September 30, 2006, we carried a total of $1.1 billion of reinsurance recoverables for paid and unpaid losses and LAE. Of the $1.1 billion in reinsurance recoverable, $11.5 million was the current recoverable at September 30, 2006 on paid losses and $1.1 billion was recoverable on unpaid losses and therefore was not currently due at September 30, 2006. With the exception of certain losses assumed from the Fund discussed below, these recoverables are unsecured. The reinsurance recoverables on unpaid losses will become current as we pay the related claims. If we are unable to collect on our reinsurance recoverables, our financial condition and results of operations could be materially adversely affected.

Our assumption of the assets, liabilities and operations of the Fund covered all losses incurred by the Fund prior to January 1, 2000, pursuant to legislation passed in the 1999 Nevada legislature. We only obtained reinsurance covering the losses incurred prior to July 1, 1995, and we could be liable for all of those losses if the coverage provided by the LPT Agreement proves inadequate or we fail to collect from the reinsurers party to such transaction.

On January 1, 2000, our Nevada insurance subsidiary assumed all of the assets, liabilities and operations of the Fund, including losses incurred by the Fund prior to such date. Our Nevada insurance subsidiary also assumed the Fund’s rights and obligations associated with the LPT Agreement that the Fund entered into with third party reinsurers with respect to its losses incurred prior to July 1, 1995. The LPT Agreement was a retroactive 100% quota share reinsurance agreement under which the Fund initially ceded $1.525 billion in liabilities for the incurred but unpaid losses and LAE related to claims incurred prior to July 1, 1995, for consideration of $775 million in cash. The LPT Agreement provides coverage for losses up to $2 billion, excluding losses for burial and transportation expenses, and

paid losses under the LPT Agreement totaled $353.6 million through September 30, 2006. Accordingly, to the extent that the Fund's outstanding losses for claims with original dates of injury prior to July 1, 1995 exceed $2 billion, they will not be covered by the LPT Agreement and we will be liable for those losses to that extent. As of September 30, 2006, the estimated remaining liabilities subject to the LPT Agreement were approximately $1 billion.

The reinsurers under the LPT Agreement agreed to assume responsibilities for the claims at the benefit levels which existed in June 1999. Accordingly, if the Nevada legislature were to increase the benefits payable for the pre-July 1, 1995 claims, we would be responsible for the increased benefit costs to the extent of the legislative increase. Similarly, if the credit rating of any of the third party reinsurers that are party to the LPT Agreement were to fall below ''A−'' as determined by A.M. Best or to become insolvent, we would be responsible for replacing any such reinsurer or would be liable for the claims that otherwise would have been transferred to such reinsurer. For example, in 2002, the rating of one of the original reinsurers under the LPT Agreement, Gerling Global International Reinsurance Company Ltd., or Gerling, dropped below the mandatory ''A−'' A.M. Best rating to ''B+.'' Accordingly, we entered into an agreement to replace Gerling with National Indemnity Company, or NICO, at a cost to us of $32.8 million. We can give no assurance that circumstances requiring us to replace one or more of the current reinsurers under the LPT Agreement will not occur in the future, that we will be successful in replacing such reinsurer or reinsurers in such circumstances, or that the cost of such replacement or replacements will not have a material adverse effect on our results of operations or financial condition.

The LPT Agreement also required the reinsurers to each place assets supporting the payment of claims by them in individual trusts that require that collateral be held at a specified level. The collateralization level must not be less than the outstanding reserve for losses and a loss expense allowance equal to 7% of estimated paid losses discounted at a rate of 6%. If the assets held in trust fall below this threshold, we can require the reinsurers to contribute additional assets to maintain the required minimum level. The value of these assets at September 30, 2006 was approximately $1.1 billion. If the value of the collateral in the trusts drops below the required minimum level and the reinsurers are unable to contribute additional assets, we could be responsible for substituting a new reinsurer or paying those





claims without the benefit of reinsurance. One of the reinsurers has collateralized its obligations under the LPT Agreement by placing the stock of a publicly held corporation, with a value of $667.0 million at September 30, 2006, in a trust to secure the reinsurer's obligation of $569.4 million. The value of this collateral is subject to fluctuations in the market price of such stock. The other reinsurers have placed treasury and fixed income securities in trusts to collateralize their obligations.

For losses incurred by the Fund subsequent to June 30, 1995, we are liable for the entire loss, net of reinsurance purchased by the Fund. If the premiums collected by the Fund for policies written between July 1, 1995 and December 31, 1999 and the investment income earned on those premiums are inadequate to cover these losses, our reserves may prove inadequate and our results of operations and financial condition could be materially adversely affected.

Intense competition could adversely affect our ability to sell policies at rates we deem adequate.

The market for workers' compensation insurance products is highly competitive. Competition in our business is based on many factors, including premiums charged, services provided, financial ratings assigned by independent rating agencies, speed of claims payments, reputation, policyholder dividends, perceived financial strength and general experience. In some cases, our competitors offer lower priced products than we do. If our competitors offer more

competitive premiums, dividends or payment plans, services or commissions to independent agents, brokers and other distributors, we could lose market share or have to reduce our premium rates, which could adversely affect our profitability. Our competitors include other insurance companies, professional employer organizations, third-party administrators, self-insurance funds and state insurance funds. Our main competitors in each of the nine states in which we currently operate vary from state to state but are usually those companies that offer a full range of services in underwriting, loss control and claims. We compete on the basis of the services that we offer to our policyholders and on ease of doing business rather than solely on price. In Nevada, our three largest competitors are American International Group, Inc., Builders Insurance Company and Liberty Mutual Insurance Company. In California, our three largest competitors are the California State Compensation Insurance Fund, American International Group and Zenith National Insurance Company.

Many of our existing and potential competitors are significantly larger and possess greater financial, marketing and management resources than we do. Some of our competitors, including the California State Compensation Insurance Fund, benefit financially by not being subject to federal income tax. Intense competitive pressure on prices can result from the actions of even a single large competitor. Competitors with more surplus than us have the potential to expand in our markets more quickly than we can. Additionally, greater financial resources permit an insurer to gain market share through more competitive pricing, even if that pricing results in reduced underwriting margins or an underwriting loss. Many of our competitors are multi-line carriers that can price the workers' compensation insurance that they offer at a loss in order to obtain other lines of business at a profit. If we are unable to compete effectively, our business and financial condition could be materially adversely affected.

Our financial condition and results of operations may be materially adversely affected if we are unable to realize our investment objectives.

Investment income is an important component of our revenues and net income. Investment income primarily consists of interest and dividends on the securities we own. The ability to achieve our investment objectives is affected by factors that are beyond our control. For example, domestic or international economic or political turbulence and large-scale acts of terrorism may adversely affect the general economy and, accordingly, reduce our investment income. Interest rates are highly sensitive to many factors, including governmental monetary policies which affect the capital markets and, consequently, the value of the securities we own. Interest rates, though recently at historically low levels, have risen over the past two years. The outlook for our investment income is dependent on the future direction of interest rates, maturity schedules and the amount of cash flows from operations available for investment. The fair values of fixed maturity investments that are ''available-for-sale'' will shift as changes in interest rates occur and cause security value fluctuations reflected on our balance sheet. Our stockholders' equity will vary with future interest rate changes. Any significant decline in our investment income would have a material adverse effect on our financial condition and results of operations.



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We rely on our information technology and telecommunication systems, and the failure of these systems could materially and adversely affect our business.

Our business is highly dependent upon the successful and uninterrupted functioning of our information technology and telecommunications systems. We rely on these systems to process new and renewal business, provide customer service, administer claims and make payments on those claims, facilitate collections, and, upon completion of the implementation of our E ACCESS automated underwriting system, to automatically underwrite and administer the

policies we write. These systems also enable us to perform actuarial and other modeling functions necessary for underwriting and rate development. The failure of these systems, including due to a natural catastrophe, or the termination of any third-party software licenses upon which any of these systems is based, could interrupt our operations or materially impact our ability to evaluate and write new business. As our information technology and telecommunications systems interface with and depend on third-party systems, we could experience service denials if demand for such services exceeds capacity or such third-party systems fail or experience interruptions. If sustained or repeated, a system failure or service denial could result in a deterioration of our ability to write and process new and renewal business and provide customer service or compromise our ability to pay claims in a timely manner. Any interruption in our ability to write and process new and renewal business, service our customers or pay claims promptly could result in a material adverse effect on our business.

The insurance business is subject to extensive regulation that limits the way we can operate our business.

We are subject to extensive regulation by the insurance regulatory agencies in each state in which our insurance subsidiaries are licensed, most significantly by the insurance regulators in the States of Nevada and California, in which our insurance subsidiaries are domiciled. These state agencies have broad regulatory powers designed primarily to protect policyholders and their employees, not stockholders or other investors. Regulations vary from state to state, but typically address or include:

- standards of solvency, including risk-based capital measurements;
- restrictions on the nature, quality and concentration of investments;
- restrictions on the types of terms that we can include in the insurance policies we offer;
- mandates that may affect wage replacement and medical care benefits paid under the workers' compensation system;
- requirements for the handling and reporting of claims;
- procedures for adjusting claims, which can affect the cost of a claim;
- restrictions on the way rates are developed and premiums are determined;
- the manner in which agents may be appointed;
- establishment of liabilities for unearned premiums, unpaid losses and loss adjustment expenses and other purposes;
- limitations on our ability to transact business with affiliates;
- mergers, acquisitions and divestitures involving our insurance subsidiaries;
- licensing requirements and approvals that affect our ability to do business;
- compliance with all applicable medical privacy laws;
- potential assessments for the settlement of covered claims under insurance policies issued by impaired, insolvent or failed insurance companies; and
- the amount of dividends that ECIC may pay to EICN and that EICN may pay to EIG.

Workers' compensation insurance is statutorily provided for in all of the states in which we do business. State laws and regulations provide for the form and content of policy coverage and the rights and benefits that are available to injured workers, their representatives and medical providers. Legislation and



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regulation also impact our ability to investigate fraud and other abuses of the workers' compensation systems where we operate. Our relationships with medical providers are also impacted by legislation and regulation, including penalties

for the failure to make timely payments.

In late 2006, the California Department of Insurance initiated the rulemaking process on a set of proposed regulations governing the establishment of reserves and collateral requirements for deductible workers' compensation insurance. These regulations, if adopted, would alter the way in which reserves are established under deductible workers' compensation insurance and change the manner in which Special California Schedule P deposits are calculated. Under current California law, workers' compensation insurers are not required to count the deductible retained by their insureds when calculating their Schedule P deposit. The proposed regulations would require the inclusion of any deductible in the Schedule P deposit. As a result, insurance companies, including ECIC, would have to increase the amount of their Schedule P deposit to cover the deductible portion of any policy. At this time, we do not write any deductible policies. Were we to commence writing deductible policies in the future, and if the proposed regulations were adopted, our Schedule P deposit would need to increase and, correspondingly, these funds would no longer be available to ECIC.

Regulatory authorities have broad discretion to deny or revoke licenses for various reasons, including the violation of regulations. We may be unable to maintain all required approvals or comply fully with the wide variety of applicable laws and regulations, which are continually undergoing revision and which may be interpreted differently among the jurisdictions in which we conduct business, or to comply with the then current interpretation of such laws and regulations. In some instances, where there is uncertainty as to applicability, we follow practices based on our interpretations of regulations or practices that we believe generally to be followed by the industry. These practices may turn out to be different from the interpretations of regulatory authorities. We are also subject to regulatory oversight of the timely payment of workers' compensation insurance benefits in all the states where we operate. Regulatory authorities may impose monetary fines and penalties if we fail to pay benefits to injured workers and fees to our medical providers in accordance with applicable laws and regulations.

The NAIC has developed a system to test the adequacy of statutory capital, known as ''risk-based capital,'' which has been adopted by all of the states in which we operate. This system establishes the minimum amount of capital and surplus calculated in accordance with statutory accounting principles necessary for an insurance company to support its overall business operations. It identifies insurers that may be inadequately capitalized by looking at the inherent risks of each insurer's assets and liabilities and its mix of net premiums written. Insurers falling below a calculated threshold may be subject to varying degrees of regulatory action, including supervision, rehabilitation or liquidation. The need to maintain our risk-based capital levels may prevent us from expanding our business or meeting strategic goals in a timely manner. Failure to maintain our risk-based capital at the required levels could adversely affect the ability of our insurance subsidiaries to maintain regulatory authority to conduct our business.

In addition, the NAIC has developed the Insurance Regulatory Information System, or IRIS. IRIS was designed to provide state regulators with an integrated approach to monitor the financial condition of insurers for the purposes of detecting financial distress and preventing insolvency. IRIS consists of a statistical phase and an analytical phase whereby financial examiners review insurers' annual statements and financial ratios. The statistical phase consists of 13 key financial ratios based on year-end data that are generated from the NAIC database annually; each ratio has a ''usual range'' of results. These ratios assist state insurance departments in executing their statutory mandate to oversee the financial condition of insurance companies. Ratios of an insurance company that fall outside the usual range are generally regarded by insurance regulators as part of an early warning system. Insurance regulators will generally begin to investigate, monitor or make inquiries of an insurance company if four or more of the company's ratios fall outside the usual ranges. Although these inquiries can take many forms, regulators may require the insurance company to provide additional written explanation as to the causes of the particular ratios being outside of the usual range, the actions being taken by management to produce results that will be within the usual range in future years and what, if any, actions have been taken by the insurance regulator of the insurers' state of domicile. Regulators are not required to take action if an IRIS ratio is outside of the usual range, but depending upon the nature and scope of the particular insurance company's exception (for example, if a particular ratio indicates an insurance company has insufficient capital) regulators may

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act to reduce the amount of insurance the company can write or revoke the insurers' certificate of authority and may even place the company under supervision. As of December 31, 2005, EICN had two ratios outside the usual range and ECIC had one ratio outside the usual range; all other ratios for EICN and ECIC were within the usual range. See ''Regulation—IRIS Ratio.'' These ratios related to EICN's investment yield and the ratio of liabilities to liquid assets. EICN's investment yield ratio was one-tenth of one percent below the usual range in 2005. This was principally related to EICN's asset allocation to equities being above property and casualty insurance industry averages, in addition to its equity interest in ECIC. EICN and ECIC's liabilities to liquid assets ratios were also outside the usual range because total liabilities includes funds withheld pursuant to their inter-company pooling agreement. See ''Regulation—IRIS Ratio.'' If either EICN or ECIC has unusual results on four or more ratios in the future, they may be subject to the actions of state regulators discussed above.

This extensive regulation of our business may affect the cost or demand for our products and may limit our ability to obtain rate increases or to take other actions that we might pursue to increase our profitability. Further, changes in the level of regulation of the insurance industry or changes in laws or regulations or interpretations by regulatory authorities could impact our operations and require us to bear additional costs of compliance.

We are a holding company with no direct operations, we depend on the ability of our subsidiaries to transfer funds to us to meet our obligations, and our insurance subsidiaries' ability to pay dividends to us is restricted by law.

EIG is a holding company that transacts substantially all of its business through operating subsidiaries. Its primary assets are the shares of stock of our operating subsidiaries. The ability of EIG to meet obligations on outstanding debt, to pay stockholder dividends and to make other payments depends on the surplus and earnings of our subsidiaries and their ability to pay dividends or to advance or repay funds, and, in particular, upon the ability of our Nevada domiciled insurance company, EICN, to pay dividends to its immediate holding company and, in turn, the ability of that holding company to pay dividends to EIG.

Nevada law limits the payment of cash dividends by EICN to its immediate holding company by providing that payments cannot be made except from available and accumulated surplus money otherwise unrestricted (unassigned) and derived from realized net operating profits and realized and unrealized capital gains. A stock dividend may be paid out of any available surplus. A cash or stock dividend otherwise prohibited by these restrictions may only be declared and distributed upon the prior approval of the Nevada Commissioner of Insurance.

As of December 31, 2004 and 2005, EICN had negative unassigned surplus of $198.7 million and $71.9 million, respectively, and therefore was unable to pay a dividend to us at such dates without prior approval of the Nevada Commissioner of Insurance. At September 30, 2006, EICN had positive unassigned surplus of $23.4 million and therefore had the capability of paying a dividend to us of up to such an amount without the prior approval of the Nevada Commissioner of Insurance.

EICN must give the Nevada Commissioner of Insurance prior notice of any extraordinary dividends or distributions that it proposes to pay to its immediate holding company, even when such a dividend or distribution is to be paid out of available and otherwise unrestricted (unassigned) surplus. EICN may pay such an extraordinary dividend or distribution if the Nevada Commissioner of Insurance either approves or does not disapprove the payment within 30 days after receiving notice of its declaration. An extraordinary dividend or distribution is defined by statute to include any dividend or distribution of cash or property whose fair market value, together with that of other dividends or

distributions made within the preceding 12 months, exceeds the greater of: (a) 10% of EICN's statutory surplus as regards policyholders at the next preceding December 31; or (b) EICN's statutory net income, not including realized capital gains, for the 12-month period ending at the next preceding December 31.

On October 17, 2006, the Nevada Commissioner of Insurance granted EICN permission to pay us an aggregate of up to an additional $55 million in one or more extraordinary dividends subsequent to the successful completion of this offering and before December 31, 2008. The payment of these dividends is



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conditioned upon the expiration of the underwriters' over-allotment option period, prior repayment of any expenses of EIG and its subsidiaries arising from the conversion and this offering, the exhaustion of any proceeds retained by EIG from this offering, maintaining the risk-based capital, or RBC, total adjusted capital of EICN above a specified level on the date of declaration and payment of any particular extraordinary dividend after taking into account the effect of such dividend, and maintaining all required filings with the Nevada Division of Insurance. We may use these extraordinary dividends from EICN, as well as any ordinary dividends that we may receive over time from EICN, to pay quarterly dividends to our stockholders as described under ''Dividend Policy,'' to repurchase our stock and/or for general corporate purposes. However, the October 17, 2006 extraordinary dividend approval prohibits us from using any such extraordinary dividends to increase executive compensation.

As the direct owner of ECIC, EICN will be the direct recipient of any dividends paid by ECIC. The ability of ECIC to pay dividends to EICN is, in turn, limited by California law. California law provides that, absent prior approval of the California Insurance Commissioner, dividends can only be declared from earned surplus, excluding any earned surplus (1) derived from the net appreciation in the value of assets not yet realized, or (2) derived from an exchange of assets, unless the assets received are currently realizable in cash. In addition, California law provides that the California Insurance Commissioner must approve (or, within a 30-day notice period, not disapprove) any dividend that, together with all other such dividends paid during the preceding 12 months, exceeds the greater of: (a) 10% of ECIC's statutory surplus as regards policyholders at the preceding December 31; or (b) 100% of the net income for the preceding year. The maximum pay-out that may be made by ECIC to EICN during 2006 without prior approval is $44.6 million. Under California regulations, an additional liability, known as an excess statutory reserve, which reduces statutory surplus, must be recorded if a company's workers' compensation losses and LAE ratio is less than 65% in each of the three most recent accident years. Excess statutory reserves reduced ECIC's statutory-basis surplus by $7.5 million to $277.2 million at December 31, 2005, as filed and reported to the regulators.

Our board of directors has authorized the payment of a dividend of $0.06 per share of our common stock per quarter to our stockholders of record beginning in the second quarter of 2007. Any determination to pay dividends will be at the discretion of our board of directors and will be dependent upon our subsidiaries' payment of dividends and/or other statutorily permissible payments to us (including the payment of the extraordinary dividends referred to above), our results of operations and cash flows, our financial position and capital requirements, general business conditions, any legal, tax, regulatory and contractual restrictions on the payment of dividends (including those described above), and any other factors our board of directors deems relevant. There can be no assurance that we will declare and pay any dividends.

We are party to certain litigation involving our assumption of the assets of the Fund and this litigation, if determined unfavorably to us, could have a material adverse effect on our business.

On October 10, 2006, a qui tam action captioned State of Nevada, ex rel., David J. Otto v. Employers Insurance Company of Nevada, et al. (referred to herein as the ‘‘complaint’’) in the second judicial district court of the State of Nevada was commenced pursuant to Nevada Revised Statute 357.080 et seq. (the ‘‘Nevada False Claims Act’’). The Nevada False Claims Act authorizes a private plaintiff to commence an action on behalf of the State of Nevada under the circumstances prescribed by the statute (‘‘qui tam action’’). Nevada law requires that a qui tam action be filed under seal and remain under seal pending a decision by the Attorney General of the State of Nevada regarding whether to intervene in the action within the requisite statutory period. On March 6, 2006, the complaint was filed under seal, but the Attorney General did not intervene within the period prescribed under the Nevada qui tam statute.

The complaint alleges, among other things, that EICN has violated the provisions of the Nevada False Claims Act embodied in Nevada Revised Statutes 357.040(1)(d), (g) and (h) in connection with an allegedly unconstitutional transfer of assets from the Fund to EICN on January 1, 2000 pursuant to Amendment No. 190 to Senate Bill No. 37 (‘‘SB 37’’) passed in the 1999 Nevada Legislature and signed into law by gubernatorial proclamation allegedly in abrogation of Article 9, Section 2 of the Nevada Constitution. Article 9, Section 2 provides in pertinent part under subparagraph 2: ‘‘Any money paid for the purpose of providing compensation for industrial accidents and occupational diseases, and for



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administrative expenses incidental thereto .... must be segregated in proper accounts in the state treasury, and such money must never be used for any other purposes, and they are hereby declared to be trust funds for the uses and purposes herein specified.’’ The complaint contends that although Article 9, Section 2 requires that the assets that were transferred to EICN be held in trust for the benefit of the State of Nevada, EICN has falsely and knowingly claimed that (i) it had and has legal title to these assets, (ii) it was not and is not a trustee with respect to such assets, and (iii) it failed to report any of the assets to the State (otherwise known as a reverse false claim). The complaint also asserts a number of common law causes of action arising out of the same allegations.

Although the complaint does not specify the amount of money damages that it seeks, the complaint does seek money damages for the State of Nevada in an amount equal to three times the amount of all funds transferred to EICN under SB 37 and the gubernatorial proclamation as well as three times the amount of all rents, profits and income from the funds to transferred. The complaint also seeks declaratory and injunctive relief as well as an accounting. The plaintiff requests that he be awarded between 14 and 50 percent of any recovery by the State of Nevada, together with attorneys’ fees and costs in accordance with the Nevada False Claims Act.

While the case is in a very preliminary stage, EICN believes that it has meritorious defenses to all of the plaintiff’s claims and intends to defend the action vigorously. Nonetheless, should the plaintiff obtain an adverse judgment for the maximum amount sought in the complaint, such an adverse judgment would have a material adverse impact on EICN’s financial condition. On November 20, 2006, EICN moved to dismiss the complaint in its entirety and with prejudice. On December 20, 2006, the plaintiff opposed EICN’s motion to dismiss. No hearing has been set on EICN’s motion.

We have a limited history as a taxpayer, and, as such, we cannot predict whether the Internal Revenue Service (or other taxing authorities) could assert any tax deficiencies against us that could have a material adverse effect on our financial condition and results of operations.

We commenced operations as an insurance company owned by our policyholders, also known as a private mutual insurance company, on January 1, 2000 when EICN assumed the assets, liabilities and operations of the Fund. While the Fund had over 80 years of workers' compensation experience in Nevada, it was not subject to U.S. federal income taxation prior to 2000 because it was a part of the State of Nevada. EICN became subject to U.S. federal income taxation from and after January 1, 2000. Although we believe that EICN has properly reported and paid its U.S. federal income taxes in all material respects, we have never been audited by the Internal Revenue Service and, if we were audited, we cannot predict whether the Internal Revenue Service would assert any tax deficiencies that could result in our paying additional taxes that could have a material adverse effect on our financial condition and results of operations.

Our profitability may be adversely impacted by inflation, legislative actions and judicial decisions.

The effects of inflation could cause claims costs to rise in the future. Our reserve for losses and LAE includes assumptions about future payments for settlement of claims and claims handling expenses, such as medical treatment and litigation costs. In addition, judicial decisions and legislative actions continue to broaden liability and policy definitions and to increase the severity of claims payments. To the extent inflation and these legislative actions and judicial decisions cause claims costs to increase above reserves established for these claims, we will be required to increase our loss reserves with a corresponding reduction in our net income in the period in which the deficiency is identified.

Administrative proceedings or legal actions involving our insurance subsidiaries could have a material adverse effect on our business, results of operations or financial condition.

Our insurance subsidiaries are involved in various administrative proceedings and legal actions in the normal course of their insurance operations. Our subsidiaries have responded to the actions and intend to defend against these claims. These claims concern issues including eligibility for workers' compensation insurance coverage or benefits, the extent of injuries, wage determinations and disability ratings. Adverse decisions in multiple administrative proceedings or legal actions could require us to pay significant amounts in the aggregate or to change the manner in which we administer claims, which could have a material adverse effect on our financial results.



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If we cannot obtain adequate or additional capital on favorable terms, including from writing new business and establishing premium rates and reserve levels sufficient to cover losses, we may not have sufficient funds to implement our future growth or operating plans and our business, financial condition or results of operations could be materially adversely affected.

Our ability to write new business successfully and to establish premium rates and reserves at levels sufficient to cover losses will generally determine our future capital requirements. If we have to raise additional capital, equity or debt, financing may not be available on terms that are favorable to us. In the case of equity financings, dilution to our stockholders could result. In any case, such securities may have rights, preferences and privileges that are senior to those of our shares of common stock. In the case of debt financings, we may be subject to covenants that restrict our ability to freely operate our business. If we cannot obtain adequate capital on favorable terms or at all, we may not have sufficient funds to implement our future growth or operating plans and our business, financial condition or results of operations could be materially adversely affected.

Our business is largely dependent on the efforts of our management because of its industry expertise, knowledge of our markets and relationships with the independent agents and brokers that sell our products, and the loss of any members of our management team could disrupt our operations and have a material adverse affect on our ability to execute on our strategies.

Our success will depend in substantial part upon our ability to attract and retain qualified executive officers, experienced underwriting personnel and other skilled employees who are knowledgeable about our business. The current success of our business is dependent in significant part on the efforts of Douglas Dirks, our president and chief executive officer, Martin Welch, the president and chief operating officer of our insurance subsidiaries, and William Yocke, our executive vice president and chief financial officer. Many of our regional and local officers are also critical to our operations because of their industry expertise, knowledge of our markets and relationships with the independent agents and brokers who sell our products. We have entered into employment agreements with certain of our key executives. These employment agreements are for a set term of three years and we may terminate the agreements for cause, including but not limited to material breach by the executive, willful violation of any law, rule or regulation by the executive and conviction of the executive for any felony or crime, including moral turpitude. For a description of the key terms and provisions of those agreements, see ‘‘Compensation Discussion and Analysis.’’ We do not maintain key man life insurance for those executives. If we were to lose the services of members of our management team or key regional or local officers, we may be unable to find replacements satisfactory to us and our business. As a result, our operations may be disrupted and our financial performance may be adversely affected.

Risks Related to the Conversion

A challenge to the Nevada Commissioner of Insurance’s approval of the application for conversion could result in uncertainty regarding the terms of our conversion and could reduce the market price of our common stock.

Nevada law requires that the plan of conversion be approved by the Nevada Commissioner of Insurance through the issuance of both an initial order, following a public hearing, and a final order approving the application for conversion.

On August 22, 2006, we filed an application for approval of the plan of conversion with the Nevada Commissioner of Insurance. The Nevada Commissioner of Insurance held a public hearing on the application for conversion on October 26, 2006 and issued an initial order approving the application for conversion on November 29, 2006, based upon, among other things, a determination that the plan of conversion is fair and equitable to our eligible members. The initial order of the Nevada Commissioner of Insurance approving the application for conversion did not address the fairness of the plan of conversion to purchasers of common stock in this offering.

At a special meeting of our members on January 13, 2007, the plan of conversion, including the amended and restated articles of incorporation of EIG, was approved by the required votes of our members. On January 13, 2007, the Nevada Commissioner of Insurance issued a final order approving the application for conversion.



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Nevada law provides that any party aggrieved by a final order of the Nevada Commissioner of Insurance approving the plan of conversion may petition for judicial review in a state district court. Under Nevada Revised Statutes 233B.035, for the purposes of this section ‘‘party’’ means ‘‘each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party, in any contested case.’’ Under Nevada law, judicial

review of a decision of the Nevada Commissioner of Insurance must be sought by initiating an action under the Nevada Administrative Procedure Act in the appropriate district court within thirty days of receipt of the final order. A successful challenge could result in injunctive relief, a modification of the plan of conversion or the Nevada Commissioner of Insurance's approval of the plan of conversion being set aside. In addition, a successful challenge could result in substantial uncertainty relating to the terms and effectiveness of the plan of conversion, and an extended period of time might be required to reach a final determination. Because Nevada law provides that only eligible members are entitled to receive consideration as part of the conversion, certain of our members will not receive consideration and thus may have a greater incentive to challenge the conversion. All eligible members were given the option to request cash consideration rather than common stock. Some policyholders who elect to receive cash instead of common stock as consideration in the conversion may nevertheless receive a portion of their overall consideration in common stock if there is insufficient cash available for cash payment to policyholders. If this occurs, those policyholders who elected to receive cash instead of common stock may be more likely to challenge the conversion. Based on the number of cash elections received from our members, we believe that each eligible member who elected to receive their consideration in the form of cash will receive some portion of their overall consideration in the form of common stock.

In order to successfully challenge the Nevada Commissioner of Insurance's approval of the application for conversion, a challenging party would have to sustain the burden of showing that approval was arbitrary, capricious, an abuse of discretion, made in violation of lawful procedures, clearly erroneous in view of the substantial evidence on the whole record, in violation of constitutional or statutory provisions, in excess of the statutory authority of the Nevada Commissioner of Insurance or affected by an error of law. Such an outcome would likely reduce the market price of our common stock, would likely be materially adverse to purchasers of our common stock, and would likely have a material adverse effect on our results of operations and financial condition.

We currently are not aware of any lawsuits or proceedings challenging the initial or final orders issued by the Nevada Commissioner of Insurance approving the application for conversion. However, we cannot assure you that no such lawsuits or proceedings will be commenced.

The market price of our common stock may decline if persons receiving common stock as consideration in the conversion sell their stock in the public market.

Substantially all of the estimated 25,965,221 shares of our common stock to be distributed as consideration to eligible members in the conversion will be freely tradable, and eligible members receiving these shares in the conversion will not be required to pay any cash for them. The sale of substantial amounts of common stock in the public market, or the perception that such sales could occur, could reduce the prevailing market price for our common stock. In particular, some eligible members who elect to receive cash instead of common stock as consideration in the conversion may nevertheless receive common stock if there is insufficient cash available to satisfy the elective cash requirements. Those eligible members who elect to receive cash instead of common stock may be especially likely to sell the shares of common stock they receive in the conversion to realize cash proceeds. This may increase selling pressure on our common stock.

Risks Related to Our Industry

Assessments by guaranty funds and other assessments may reduce our profitability.

Most states have guaranty fund laws under which insurers doing business in the state are required to fund policyholder liabilities of insolvent insurance companies. Generally, assessments are levied by guaranty associations within the state, up to prescribed limits, on all insurers doing business in that state on the basis of the proportionate share of the premiums written by insurers doing business in that state in the lines of business in which the impaired, insolvent or failed insurer is engaged. Maximum

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contributions required by law in any one state in which we currently offer insurance vary between 1% and 2% of premiums written. We recorded an estimate of $2.0 million and $2.2 million for our expected liability for guaranty fund assessments at September 30, 2006 and December 31, 2005, respectively. As of September 30, 2006, all states in which we operate, other than California, had not levied any assessments; therefore, there are no expected recoveries as of September 30, 2006. A guaranty fund payment on deposit balance of $10.1 million as of September 30, 2006 was recorded as an asset for assessments paid to the California Insurance Guaranty Association that includes policy surcharges still to be collected in the future. The assessments levied on us may increase as we increase our premiums written or if we write business in additional states. In some states, we receive a credit against our premium taxes for guaranty fund assessments. The effect of these assessments or changes in them could reduce our profitability in any given period or limit our ability to grow our business.

Government authorities are continuing to investigate the insurance industry, which may materially adversely affect our financial condition and results of operations.

The attorneys general for multiple states and other insurance regulatory authorities have been investigating a number of issues and practices within the insurance industry relating to allegations of improper special payments, price-fixing, bid-rigging, improper accounting practices and other alleged misconduct, including payments made by insurers to brokers and the practices surrounding the placement of insurance business. These investigations of the insurance industry in general, whether involving our company specifically or not, together with any legal or regulatory proceedings, related settlements and industry reform or other changes arising therefrom, may materially adversely affect our business and future prospects. Any such investigation or threatened investigation may materially adversely affect our financial condition and results of operations.

Proposed legislation could impact our operations.

From time to time, there have been various attempts to regulate insurance at the federal level. Currently, the federal government does not directly regulate the business of insurance. However, federal legislation and administrative policies in several areas can significantly and adversely affect insurance companies. These areas include securities regulation, privacy and taxation. In addition, various forms of direct federal regulation of insurance have been proposed. These proposals include bills pending before Congress that would create a federal insurance regulatory agency, but would allow insurers to choose to be regulated either by such agency or under the applicable existing state regime. We cannot predict whether this or other proposals will be adopted, or what impact, if any, such proposals or, if enacted, such laws, could have on our business, financial condition or results of operations.

Risk Related to this Offering

The requirements of being a public company may strain our resources, including personnel, and cause us to incur additional expenses.

As a public company, we will be subject to the reporting requirements of the Securities Exchange Act of 1934 (the ‘‘Exchange Act’’) and the Sarbanes-Oxley Act of 2002 (the ‘‘Sarbanes-Oxley Act’’). These requirements may strain resources, including personnel, and cause us to incur additional expenses. The Exchange Act requires that after the offering we file annual, quarterly and current reports with respect to our business and financial condition. The Sarbanes-Oxley Act requires that we maintain effective disclosure controls and procedures and internal controls over

financial reporting. In order to maintain and improve the effectiveness of these controls, significant resources and management oversight will be required. This may divert management's attention from other business concerns. Upon consummation of this offering, our costs will increase as a result of having to comply with the Exchange Act, the Sarbanes-Oxley Act and the New York Stock Exchange listing requirements, which may require us, among other things, to enhance our existing internal audit function. Changes associated with fully implementing effective disclosure controls and procedures and internal controls over financial reporting may take longer than we anticipate and may result in potentially significant extra cost. We expect these new rules and regulations to increase our legal and financial compliance costs and to make some activities more time consuming and costly. We also expect these new rules and regulations to make it more difficult



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and more expensive for us to obtain director and officer liability insurance, and we may be required to accept reduced coverage or incur substantially higher costs to obtain coverage. These new rules and regulations could also make it more difficult for us to attract and retain qualified members of our board of directors, particularly those serving on our audit committee.

We will be exposed to risks, including potentially significant expenses and business process changes, relating to evaluations of our internal controls over financial reporting required by Section 404 of the Sarbanes-Oxley Act and failure to implement the requirements of Section 404 in a timely manner or the discovery of material weaknesses in our controls could expose us to material expenses.

As a public company, we will be required to comply with Section 404 of the Sarbanes-Oxley Act by no later than December 31, 2007. We are in the process of evaluating our internal control systems to allow management to report on, and our independent auditors to assess, our internal controls over financial reporting. We have hired a consultant to assist us with our Section 404 compliance process. We cannot be certain, however, as to the timing of the completion of our evaluation, testing and remediation actions or the impact of the same on our operations, nor can we assure you that our compliance with Section 404 will not result in significant additional expenditures. Compliance with Section 404 will require the devotion of substantial time and attention from our management and may require us to secure additional personnel. For example, we anticipate that we will hire additional non-management compliance and reporting staff over the next year in order to ensure we can meet our reporting obligations. Furthermore, upon completion of this process, we may identify control deficiencies of varying degrees of severity that remain unremediated. As a public company, we will be required to disclose, among other things, control deficiencies that constitute a ''material weakness.'' A ''material weakness'' is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the annual or interim financial statements will not be prevented or detected. If we fail to implement the requirements of Section 404 in a timely manner, we might be subject to sanctions or investigation by regulatory agencies such as the SEC. In addition, failure to comply with Section 404 or the disclosure by us of a material weakness may cause investors to lose confidence in our financial statements and the trading price of our common stock may decline. If we fail to remedy any material weakness, our financial statements may be inaccurate, our access to the capital markets may be restricted and the trading price of our common stock may decline.

There has been no prior market for our common stock, and you may lose all or a part of your investment.

There has not been any public market for our common stock prior to this offering. An active trading market for our common stock may not develop after this offering. If an active trading market develops, it may not continue and

trading in and the price of our common stock may fluctuate widely as a result of a number of factors, many of which are beyond our control, including:

- failure of security analysts to cover our stock;
- variations in our quarterly operating results;
- changes in operating and stock performance of similar companies;
- changes in earnings estimates and market price targets by securities analysts;
- investor perception of the workers' compensation insurance industry and of our company;
- results of operations that vary from those expected by securities and other market analysts and investors;
- future sales of our securities;
- sales or the perception of such sales of our stock received by our members as consideration in the conversion;
- litigation developments;
- regulatory actions;
- departures of key personnel; and





- general market conditions, including market volatility.

A significant decline in our stock price could result in substantial losses for individual stockholders and could lead to costly and disruptive securities litigation.

The initial public offering price of our common stock was determined based upon a number of factors and may not be indicative of prices that will prevail following the completion of this offering. In addition, the stock market in recent years has experienced substantial price and trading volume fluctuations that sometimes have been unrelated or disproportionate to the operating performance of companies whose shares are publicly traded. As a result, the trading price of shares of our common stock may be below the initial public offering price, you may be unable to sell your shares of common stock at or above the price that you pay to purchase them, and you may lose some or all of your investment.

Insurance laws of Nevada and other applicable states and certain provisions of our charter documents and Nevada corporation law could prevent or delay a change of control of us and could also adversely affect the market price of our common stock.

Under Nevada insurance law and our amended and restated articles of incorporation that will become effective upon completion of the conversion, for a period of five years following the effective date of the plan of conversion or, if earlier, until such date as we no longer directly or indirectly own a majority of the outstanding voting stock of EICN, no person may directly or indirectly acquire or offer to acquire in any manner beneficial ownership of 5% or more of any class of our voting securities without the prior approval by the Nevada Commissioner of Insurance of an application for acquisition under Section 693A.500 of the Nevada Revised Statutes. Under Nevada insurance law, the Nevada Commissioner of Insurance may not approve an application for such acquisition unless the Commissioner finds that (1) the acquisition will not frustrate the plan of conversion as approved by our members and the Commissioner, (2) the board of directors of EICN has approved the acquisition or extraordinary circumstances not contemplated in the plan of conversion have arisen which would warrant approval of the acquisition, and (3) the acquisition is consistent with the purpose of relevant Nevada insurance statutes to permit conversions on terms and conditions that are fair and equitable to the members eligible to receive consideration. Accordingly, as a practical

matter, any person seeking to acquire us within five years after the effective date of the plan of conversion may only do so with the approval of the board of directors of EICN.

In addition, the insurance laws of Nevada and California generally require that any person seeking to acquire control of a domestic insurance company must obtain the prior approval of the insurance commissioner. Furthermore, insurance laws in many other states contain provisions that require pre-notification to the insurance commissioners of those states of a change in control of a non-domestic insurance company licensed in those states. While these pre-notification statutes do not authorize the state insurance departments to disapprove the change of control, they authorize regulatory action (including a possible revocation of our authority to do business) in the affected state if particular conditions exist, such as undue market concentration. Any future transactions that would constitute a change of control of us may require prior notification in the states that have pre-acquisition notification laws. Because we have an insurance subsidiary domiciled in Nevada and another insurance subsidiary domiciled in California and licensed in numerous other states, any future transaction that would constitute a change in control of us would generally require the party seeking to acquire control to obtain the prior approval of the Nevada Commissioner of Insurance and the California Insurance Commissioner and may require pre-acquisition notification in those states in which we are licensed to conduct business that have adopted pre-acquisition notification provisions. ‘‘Control’’ is generally presumed to exist through the direct or indirect ownership of 10% or more of the voting securities of a domestic insurance company or of any entity that controls a domestic insurance company. Obtaining these approvals may result in a material delay of, or deter, any such transaction. Therefore, any person seeking to acquire a controlling interest in us would face regulatory obstacles which may delay, deter or prevent an acquisition that stockholders might consider in their best interests.

Provisions of our amended and restated articles of incorporation and amended and restated by-laws that will become effective on completion of the conversion could discourage, delay or prevent a merger, acquisition or other change in control of us, even if our stockholders might consider such a change in



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control to be in their best interests. These provisions could also discourage proxy contests and make it more difficult for you and other stockholders to elect directors and take other corporate actions. In particular, our amended and restated articles of incorporation and amended and restated by-laws will include provisions:

- dividing our board of directors into three classes;
- eliminating the ability of our stockholders to call special meetings of stockholders;
- permitting our board of directors to issue preferred stock in one or more series;
- imposing advance notice requirements for nominations for election to our board of directors or for proposing matters that can be acted upon by stockholders at the stockholder meetings;
- prohibiting stockholder action by written consent, thereby limiting stockholder action to that taken at a meeting of our stockholders; and
- providing our board of directors with exclusive authority to adopt or amend our by-laws.

These provisions could limit the price that investors are willing to pay in the future for shares of our common stock. These provisions might also discourage a potential acquisition proposal or tender offer, even if the acquisition proposal or tender offer is at a premium over the then current market price for our common stock.

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## FORWARD-LOOKING STATEMENTS AND ASSOCIATED RISKS

This prospectus contains forward-looking statements, including statements regarding our expected financial position, business, financing plans, litigation, future premiums, revenues, earnings, pricing, investments, business relationships, expected losses, loss reserves, competition and rate increases. These forward-looking statements reflect our views with respect to future events and financial performance. The words ‘‘believe,’’ ‘‘expect,’’ ‘‘plans,’’ ‘‘intend,’’ ‘‘project,’’ ‘‘est ‘‘may,’’ ‘‘should,’’ ‘‘will,’’ ‘‘continue,’’ ‘‘potential,’’ ‘‘forecast’’ and ‘‘anticipate’’ and similar expressions identify forward-l statements. Although we believe that these expectations reflected in such forward-looking statements are reasonable, we can give no assurance that the expectations will prove to be correct. Actual results may differ from those expected due to risks and uncertainties, including those discussed in ‘‘Risk Factors’’ and the following:

- accuracy in projecting loss reserves;
- development of claims and the effect on loss reserves;
- rate regulation;
- the adequacy and accuracy of our pricing methodologies;
- our dependence on a concentrated geographic area and on the workers’ compensation industry;
- effects of acts of war, terrorism or natural or man-made catastrophes;
- non-receipt of expected payments, including reinsurance receivables;
- the possible unavailability of reinsurance on satisfactory terms;
- the impact of competition and pricing environments;
- the effect of the performance of the financial markets on investment income and fair values of investments;
- changes in asset valuations;
- the possible failure of our information technology or communications systems;
- changes in legislation and regulations;
- adverse state and federal judicial decisions;
- litigation and government proceedings;
- the possible loss of the services of any of our executive officers or other key personnel;
- cyclical changes in the insurance industry;
- investigations into issues and practices in the insurance industry;
- changes in interest rates; and
- changes in demand for our products.

The foregoing factors should not be construed as exhaustive and should be read in conjunction with the other cautionary statements that are included in this prospectus.

These forward-looking statements are subject to certain risks and uncertainties that could cause actual results to differ materially from historical or anticipated results, depending on a number of factors. These risks and uncertainties include, but are not limited to, those listed in this prospectus under the heading ‘‘Risk Factors.’’ All subsequent written and oral forward-looking statements attributable to us or individuals acting on our behalf are expressly qualified in their entirety by these cautionary statements. We caution you not to place undue reliance on these forward-looking statements, which speak only as of the date of this prospectus. We undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law. Before making an investment decision, you should carefully consider all of the factors identified in this prospectus that could cause actual results to differ.

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THE CONVERSION

The following section provides a summary of the conversion and the terms of our plan of conversion. The description of the conversion in the following sections is only a summary and is qualified in its entirety by reference to the complete terms of the plan of conversion, a copy of which has been filed as an exhibit to the registration statement of which this prospectus forms a part.

Plan of Conversion

Adoption and Approval of the Plan of Conversion

Our board of directors unanimously approved and adopted the plan of conversion on August 17, 2006, and unanimously approved an amended and restated plan of conversion on October 3, 2006. The principal feature of the plan of conversion is the conversion of EIG from a mutual insurance holding company to a stock corporation. In this prospectus, we refer to the conversion, which will occur pursuant to the provisions of Nevada law, as the ‘‘conversion.’’

Because EIG is currently a mutual insurance holding company organized under the laws of the State of Nevada, the conversion is governed by Nevada law. As a mutual insurance holding company, EIG currently does not have stockholders. Instead it has members, generally comprised of all policyholders of our Nevada insurance subsidiary, EICN.

Pursuant to Nevada law and the plan of reorganization that EICN adopted and amended in 2004, and the by-laws of EIG, to reorganize into a mutual insurance holding company structure, the plan of conversion, including the amendments to EIG’s articles of incorporation contemplated thereby, must be approved by both the affirmative vote of a majority of EIG’s members, as of a record date fixed by EIG’s board of directors in accordance with EIG’s by-laws, and by the affirmative vote of not less than two-thirds of the eligible members voting in person or by proxy at the meeting of EIG’s members called to vote on the plan of conversion.

Under Nevada law, only eligible members of EIG are entitled to receive consideration if the conversion is completed. Nevada law defines an eligible member as a person or persons who, on the adoption date, was the owner of one or more in force insurance policies with EICN, as reflected in our records. Nevada law defines adoption date as the date our board of directors adopts a resolution proposing a plan of conversion and an amendment to our articles of incorporation. The consideration to be distributed to the eligible members in the plan of conversion and in accordance with Nevada law must be not less than the surplus of EICN as reported in the statutory financial statements most recently filed by EICN with the Nevada Division of Insurance prior to completion of the conversion, and may be in the form of cash, stock or other valuable consideration approved by the Nevada Commissioner of Insurance.

Nevada law also requires that the application for conversion be approved by the Nevada Commissioner of Insurance, by issuance of both an initial order, following a public hearing, and a final order approving the application for conversion. Under the terms of the plan of conversion, EIG’s conversion will not become effective until we have obtained these approvals and the Nevada Commissioner of Insurance has issued a new certificate of authority to EICN. The articles of incorporation and by-laws of EIG will be amended and restated effective upon completion of the conversion in the form filed as exhibits to the registration statement of which this prospectus forms a part.

On August 22, 2006, we filed an application for conversion with the Nevada Commissioner of Insurance. The Nevada Commissioner of Insurance held a public hearing on the plan of conversion on October 26, 2006 and issued an initial order approving the application for conversion on November 29, 2006, based upon, among other things, a determination that the plan of conversion is fair and equitable to our eligible members.

At a special meeting of our members on January 13, 2007, the plan of conversion, including the amended and restated articles of incorporation of EIG, was approved by the required votes of our members. On January 13, 2007, the Nevada Commissioner of Insurance issued a final order approving the application for conversion.

Any final approval order issued by the Nevada Commissioner of Insurance is subject to review in accordance with the procedures provided for under Nevada law. See ‘‘Risk—Factors—Risks Related to



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The Conversion—A challenge to the Nevada Commissioner of Insurance’s approval of the application for conversion could result in uncertainty regarding the terms of our conversion and reduce the market price of our common stock.’’

Effects of the Conversion

This offering is being made in connection with the completion of the conversion of EIG to a stock corporation, and each of the effectiveness of the conversion and the completion of this offering are conditioned upon the occurrence of the other.

Upon completion of our conversion, EIG will become a Nevada stock corporation and will change its name to ‘‘Employers Holdings, Inc.,’’ and all of the membership interests of our members will be extinguished. Members who are eligible under Nevada law to receive consideration in exchange for the extinguishment of their membership interests in the conversion will receive shares of our common stock, cash or a combination of both.

When the conversion and this offering are complete, EIG will be a public company and will continue to indirectly own 100% of the common stock of EICN and our other operating subsidiaries.

The following charts reflect our organizational structure before and after the completion of the conversion and this offering:

Structure Before Conversion and Completion of this Offering



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Structure After Conversion and Completion of this Offering

(1)Employers Holdings, Inc. is the name that EIG Mutual Holding Company will adopt upon consummation of its conversion from a mutual insurance holding company to a stock corporation.

(2)Employers Group, Inc. is the name that Employers Insurance Group, Inc. will adopt upon consummation of the conversion of its parent company.

Effective Date of the Conversion

The effective date of the conversion will be the date on which this offering is completed. Effectiveness of our conversion is subject to the completion of this offering and to the satisfaction of a number of conditions described below. If our conversion does not become effective for any reason, EIG will remain a mutual insurance holding company, the offering described in this prospectus will not be consummated and no consideration will be provided to our eligible members.

Conditions to Effectiveness of the Conversion

The conversion cannot be completed unless a number of conditions are satisfied, including:

- The Nevada Commissioner of Insurance must issue both an initial order, following a public hearing, and a final order approving our application for conversion; we have received both of these orders from the Nevada Commissioner of Insurance;



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- The plan of conversion, including the amendments to our articles of incorporation contemplated thereby, must be approved by our members, both by the affirmative vote of a majority of our members as of November 20, 2006, the record date fixed by our board of directors in accordance with our by-laws, and by the affirmative vote of not less than two-thirds of the eligible members voting in person or by proxy at the meeting of our members called to vote on the plan of conversion; we obtained these approvals at the special meeting of our members held on January 13, 2007;
- All authorizations, consents, orders or approvals of, or declarations or filings with, and the expiration of all waiting periods imposed by, any court or governmental or regulatory authority or agency, if any, legally required for the consummation of the conversion shall have occurred or been obtained or made;
- We must receive an opinion of Skadden, Arps, Slate, Meagher & Flom LLP or other nationally recognized tax counsel to the company, which counsel will be entitled to rely upon representation letters in form and substance reasonably satisfactory to such counsel substantially to the effect described below under ‘‘—Material U.S. Federal Income Tax Considerations of the Conversion’’;
- We must receive a favorable ‘‘no-action’’ letter or other exemptive relief from the SEC to the effect that the common stock may be distributed to eligible members under the plan of conversion without registration under the Securities Act of 1933, as amended, or the Securities Act, in reliance on the exemption provided under Section 3(a)(10) of that Act, and as to certain other federal securities law matters; we have obtained such a letter, but it does not constitute the legal conclusion of the SEC with respect to the matters covered by it, but only the SEC Staff’s position as stated in the letter that it will not recommend enforcement action against us based on the facts described in our request for no-action relief;

- The registration statement of which this prospectus forms a part must have been declared effective by the SEC under the Securities Act, no stop order suspending the effectiveness of such registration statement may have been issued by the SEC, and no proceedings for that purpose may have been initiated or threatened by the SEC; the registration statement was declared effective on the date of this prospectus;
- The shares of our common stock to be issued to eligible members under the plan of conversion and to the public in this offering must have been approved for listing on the New York Stock Exchange or the NASDAQ Stock Market as of the effective date of the conversion subject to official notice of issuance; our common stock has been approved for listing on the New York Stock Exchange, subject to official notice of issuance;
- No temporary restraining order, preliminary or permanent injunction or other order issued by any court of competent jurisdiction or other legal restraint or prohibition preventing the consummation of any of the transactions contemplated by the plan of conversion may be in effect;
- In accordance with applicable Nevada law, the total consideration to be provided to the eligible members pursuant to the plan of conversion must be equal to or greater than the surplus of EICN, as reported on line 35 of the ‘‘Liabilities, Surplus and Other Funds’’ page (or the comparable line item, if different, of the form currently in use at the relevant time) of the annual or quarterly statutory statement (as the case may be) containing financial statements prepared under Statutory Accounting Principles prescribed by the State of Nevada most recently filed by EICN with the Nevada Division of Insurance prior to the effective date of the conversion;
- We must receive an opinion of Morgan Stanley & Co. Incorporated, or another nationally-recognized financial advisor, dated as of the effective date of the conversion, to the effect that: (a) the consideration to be provided to eligible members pursuant to the plan of conversion is fair, from a financial point of view, to the eligible members, as a group, and (b) the total consideration to be provided to the eligible members pursuant to the plan of conversion is equal to or greater than the surplus of EICN, as reported on line 35 of the ‘‘Liabilities, Surplus and



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Other Funds’’ page (or the comparable line item, if different, of the form currently in use at the relevant time) of the annual or quarterly statutory statement (as the case may be) containing financial statements prepared under Statutory Accounting Principles prescribed by the State of Nevada most recently filed by EICN with the Nevada Division of Insurance prior to the effective date of the conversion;

- We must receive an opinion of Robert F. Conger, a Fellow of the Casualty Actuarial Society, Member of the American Academy of Actuaries, and a Consultant with the Tillinghast business of Towers, Perrin, Forster & Crosby, Inc., dated as of the effective date of the conversion, to the effect that: (a) all methodologies and formulas used to allocate consideration among eligible members are reasonable and (b) the allocation of consideration resulting from such methodologies and formulas is fair and equitable to eligible members, from an actuarial perspective; and
- We must have taken such action as is necessary so that as of the effective date of the conversion the composition of the board of directors of EIG and the audit, compensation and nominating and governance committees thereof, satisfies the independence requirements

specified in the plan of conversion; we believe that such independence requirements are satisfied as of the date of this prospectus.

In addition, the plan of conversion requires that (1) the gross proceeds of this offering must be not less than $125 million, and (2) we raise proceeds in this offering in an amount, net of all underwriting commissions, without taking into account any proceeds received pursuant to the exercise of the underwriters' over-allotment option, at least equal to the total amount required to pay the mandatory cash consideration to eligible members described under ''—Amount and Form of Consideration—Mandatory Cash Consideration'' and to pay the fees and expenses we incur in the conversion and this offering. The Nevada Commissioner of Insurance shall issue an amended certificate of authority to EICN when we file a certificate with the Nevada Commissioner of Insurance stating that all conditions set forth in the plan of conversion have been satisfied. The conversion will be effective upon the issuance of the amended certificate of authority.

Final Order of the Nevada Commissioner of Insurance

The final order of the Nevada Commissioner of Insurance included the following requirements, among others:

- The mandatory cash requirements must include reimbursement of all funds expended, either directly or indirectly, by EICN related to the conversion and this offering;
- The employment contracts for certain executive officers in effect on October 26, 2006, may not be amended or revised, nor may any action be taken or any agreement be entered into to amend or revise such contracts, until after the earlier of the effective date or the date on which the plan of conversion is abandoned, except with respect to provisions regarding a pro rata bonus upon termination of employment, conformity to certain statutory requirements and certain non-material revisions to compensation;
- We may not enter into any underwriting agreement for this offering until we have been notified that the Nevada Commissioner of Insurance has received a written opinion from her financial advisor that we and the underwriters for this offering have complied in all material respects with the requirements of the plan of conversion regarding the conduct of this offering; we were notified that the Nevada Commissioner of Insurance received such opinion on the date of this prospectus;
- We must notify the Nevada Commissioner of Insurance of any information contained in certain documents related to the conversion that we determine constitute a material misstatement or omission;
- We must notify the Nevada Commissioner of Insurance if we receive any written notice of any legal or administrative proceeding challenging or in any way relating to or affecting the conversion; and



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- We may not announce, initiate, privately negotiate, or otherwise commence or engage in any open market repurchases of shares of common stock until at least five business days after we or the transfer agent mails a notice of share ownership to each eligible member entitled to receive shares of common stock as consideration pursuant to the plan of conversion. Upon receipt of such notice, eligible members who hold their shares of common stock in book entry form must have the ability to sell or transfer their shares through procedures established by the transfer agent and described in such notice.

Payment of Consideration to Eligible Members

Pursuant to the Nevada conversion statute, a mutual insurance holding company must distribute consideration, in the form of cash, stock or other consideration as may be approved by the Commissioner, to the eligible members of the converting mutual insurance holding company. Under the terms of the plan of conversion and in accordance with the Nevada conversion statute, the total amount of consideration must be equal to or greater than the surplus of EICN as reported in the statutory financial statements most recently filed by EICN with the Nevada Division of Insurance prior to completion of the conversion. Eligible member is defined under the Nevada conversion statute to mean those persons who were members of the converting mutual insurance holding company on the date its board of directors adopted a resolution proposing a plan of conversion and an amendment to its articles of incorporation.

Eligible Members

Under applicable Nevada law, those persons who were owners of one or more policies issued by EICN that were in force as of August 17, 2006, the date the plan of conversion was initially proposed, approved and adopted by our board of directors, and who therefore had a membership interest in EIG as of such date, are eligible members entitled to receive consideration in the conversion. Persons who become members after the adoption date are not eligible under Nevada law to receive consideration in the conversion although their membership interests will be extinguished if the conversion is completed. In addition, persons who are policyholders of our California domiciled insurance subsidiary, ECIC, do not have a membership interest in EIG and therefore are not entitled to receive consideration in the conversion.

Whether or not a policy is in force is determined based on our company records. In general, a policy is in force on a given day if it has been issued and is in effect and has not expired or been cancelled or otherwise terminated as of that day. A policy that is in force will remain in force as long as it has not expired, been cancelled or otherwise terminated. If a policy has lapsed or been cancelled for nonpayment of premiums, it will generally be deemed to remain in force during any applicable grace period in accordance with EICN’s ordinary past practice, subject to limitations set forth in the plan of conversion.

Allocation of Aggregate Consideration

The aggregate consideration to be received by eligible members will be allocated among them in accordance with the allocation provisions set forth in the plan of conversion, which provide for both a fixed allocation component, intended to compensate all eligible members equally for the extinguishment of their membership interests, and a variable allocation component, based upon both the total number of days during which an eligible member has been a policyholder of EICN during the period from January 1, 2000 through August 17, 2006 and the total amount of premium paid by an eligible member to EICN in respect of coverage during the period from January 1, 2001 through August 17, 2006. The formulae in the plan of conversion allocate the aggregate consideration among the eligible members through the allocation of 50,000,000 notional ‘‘allocable shares.’’ These allocable shares are then used to determine the actual form and amount of consideration that eligible members will receive, as described below.

Amount and Form of Consideration

The consideration to be received by eligible members will be in the form of shares of our common stock, cash or a combination of both.

Mandatory Cash Consideration. Under the terms of the plan of conversion, eligible members must receive cash consideration in exchange for the extinguishment of their membership interests in the following limited circumstances:

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- the eligible member's address for mailing purposes as shown on our records is an address at which mail is undeliverable or is deemed to be undeliverable in accordance with guidelines approved by the Nevada Commissioner of Insurance; or
- the eligible member's address for mailing purposes as shown on our records is located outside the United States of America.

An eligible member also will be required to receive cash consideration in the conversion if we determine in good faith to the satisfaction of the Nevada Commissioner of Insurance that it is not reasonably feasible or appropriate to provide such eligible member with common stock in exchange for the extinguishment of its membership interest. This provision will apply, for example, to any governmental agency or authority or school district that provides evidence reasonably satisfactory to us of a legal restriction or limitation on its ability to own or hold shares of our common stock.

Common Stock. In all other cases, subject only to the circumstances described in the following two sections, eligible members will receive shares of our common stock in exchange for the extinguishment of their membership interests in the conversion.

Cash Consideration to Non-Electing Members. In circumstances where the net proceeds from this offering and from the exercise of the underwriters' over-allotment option exceed the amount of funds necessary to pay the mandatory cash requirements and the elective cash requirements, we have the option to pay in cash a portion of the consideration to be paid to all eligible members not electing cash provided that (1) we distribute such cash pro rata in proportion to the number of shares allocated to them pursuant to the allocation provisions of the plan of conversion (with adjustments to prevent the issuance of any fractional shares), (2) the aggregate amount of cash that we so distribute does not exceed the limit on such amount described in ''Use of Proceeds'' and (3) the consideration we distribute to such eligible members includes an adjustment in respect of any required top up amount. Based on our final tabulation of the cash elections we received from eligible members, we will not have the option to elect to distribute cash consideration to eligible members who have not elected cash.

Cash Elections. All eligible members who are entitled to receive shares of our common stock in the conversion will be permitted, prior to the vote of the members entitled to vote on the plan of conversion, to express a preference to receive cash, rather than common stock, as consideration for the extinguishment of their membership interests. However, as described below, if sufficient net proceeds from this offering (including from the exercise of the underwriters' over-allotment option) are not available to satisfy all cash elections in full, the remaining cash available after payment of all mandatory cash requirements as described above will be allocated among eligible members electing cash pro rata in proportion to the number of shares allocated to them pursuant to the allocation provisions of the plan of conversion (with adjustments to prevent the creation of any odd-lots or the issuance of any fractional shares).

Calculation and Distribution of Consideration

- Cash. The amount of cash to be received by an eligible member receiving only cash will be equal to the number of shares that have been allocated to such eligible member under the allocation provisions of the plan of conversion, multiplied by the price per share at which the common stock is sold in this offering (net of any applicable withholding tax).
- Common Stock. The number of shares of common stock to be received by an eligible member receiving only common stock will be equal to the number of shares allocated to such member under the allocation provisions of the plan of conversion.
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Distribution of Common Stock to Eligible Members Electing Cash. If we pay some consideration in the form of stock to eligible members who have elected to receive cash, under the circumstances described below under ‘‘—Limits on Available Cash’’, cash available to satisfy cash elections will be allocated and distributed among such eligible members pro rata in proportion to the total number of shares allocated to them pursuant to the plan of conversion, and each such eligible member also will receive a number of shares of common stock equal to (1) the total number of shares allocated to such eligible member under the allocation provisions of the plan of conversion minus (2) the quotient obtained by dividing the total amount of cash allocated and



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distributed to such eligible member by the price per share at which the common stock is sold in this offering (with adjustments to prevent the creation of any odd-lots or the issuance of any fractional shares). Based on the number of cash elections received from our members, we believe that each eligible member who elected to receive their consideration in the form of cash will receive some portion of their overall consideration in the form of common stock.

Limits on Available Cash

In the event that the net proceeds from this offering and the exercise of the underwriters’ over-allotment option (after payment of all mandatory cash requirements) are not sufficient to fund the distribution of cash consideration to all eligible members electing to receive cash instead of common stock, the remaining proceeds will be allocated pro rata among all eligible members electing to receive cash, in proportion to the number of shares allocated to such eligible members pursuant to the allocation provisions of the plan of conversion (with adjustments to prevent the creation of any odd-lots or the issuance of any fractional shares).

The maximum number of allocated shares for which cash will be available will depend on a number of factors, including the amount of net proceeds from this offering and the percentage of eligible members who have elected to receive cash.

Actuarial Opinion

We have retained the Tillinghast business of Towers, Perrin, Forster & Crosby, Inc. as our actuarial advisor to advise us in connection with allocating the aggregate consideration to be received by eligible members in the conversion. On October 26, 2006, Robert F. Conger, a Fellow of the Casualty Actuarial Society, Member of the American Academy of Actuaries, and a Consultant with the Tillinghast business of Towers, Perrin, Forster & Crosby, Inc. delivered an actuarial opinion that (i) all methodologies and formulas used to allocate consideration among eligible members are reasonable and (ii) the proposed allocation of consideration produced by such methodologies and formulas is fair and equitable to eligible members, from an actuarial perspective. A copy of the opinion is attached as Annex A to this prospectus.

Closed Block

As required by Nevada law, we will establish a closed block at the effective time of the conversion for the preservation of the reasonable dividend expectations of eligible members and other policyholders holding policies entitling the holder to distributions from the surplus of EICN in accordance with the terms of a dividend plan or program with respect to such policy. The closed block will be created for the benefit of (1) all policies issued by EICN that are in force as of the effective time and that are participating pursuant to a dividend plan or program of EICN and

(2) all policies that are no longer in force as of the effective date but that were participating pursuant to a dividend plan or program of EICN, that have an inception date that is not earlier than 24 months prior to and not later than the effective date and for which a participating policy dividend has not been calculated, declared and paid by EICN as of the effective date. The closed block assets will consist solely of cash and U.S. treasury securities and will be segregated in a separate surplus account in an amount that is reasonably expected to cover all dividend payments on the closed block policies, assuming that (a) they earn a dividend, (b) no further losses are incurred or paid with respect to any such policies and (c) dividends are declared on the participating policies by EICN's board of directors. The assets allocated to the closed block are not expected to exceed $3.4 million. The assets allocated to the closed block are assets of EICN and are subject to the same liabilities (in the same priority) as all assets of EICN. The closed block will terminate, and the remaining assets will revert to the benefit of EICN, from and after the calculation, declaration and payment by EICN of all dividends, if any, with respect to all closed block policies following the effective time, which we expect will be approximately 24 months following the effective time.

Compensation of Directors, Officers and Employees

Except as otherwise specifically provided in the plan of conversion, no director, officer, employee or agent of EIG, or any other person, will receive any fee, commission or other valuable consideration, other than his or her usual regular salary or other compensation, including incentive compensation in the



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ordinary course of business, for aiding, promoting or assisting in connection with the transactions contemplated by the plan of conversion.

In recognition of becoming a public company, on the date of the closing of the initial public offering, we intend to make a ''founders' grant'' in the form of a nonqualified stock option to purchase 300 shares of our common stock to each full-time employee, other than senior officers, at the initial public offering stock price. Part-time employees will receive a grant to purchase 150 of our shares. We believe the ''founders' grants'' will immediately align employee interests with those of members receiving stock in the conversion and other public stockholders and reinforce the cultural change from a mutual to a public stock company. The ''founders' grants'' will vest pro rata on each of the first three anniversaries of the initial public offering date, subject to the continued employment of the employee, and have a maximum term of seven years.

Our directors, officers and employees will not receive any other stock or cash compensation at the time of completion of the conversion, except that some of our directors may receive cash and/or stock consideration indirectly through an affiliation with an eligible member that receives consideration in the conversion. See ''Certain Relationships and Related Transactions.'' EIG's equity and incentive plan will become effective upon completion of the conversion, and following the conversion stock options and other stock-based awards will be part of the overall compensation package for our directors and officers, provided that we may not award any stock options, restricted stock or other stock-based awards to any of our senior officers or directors until six months after the effective date of the conversion. See ''Compensation Discussion and Analysis.''

Except as stated above, nothing in the plan of conversion will prohibit us from adopting or establishing, or issuing common stock in connection with:

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EIG's equity and incentive plan, or any other stock option plan, stock incentive plan or other compensation or incentive plan for our directors, officers, employees and/or agents;

- any employee stock purchase plan or employee stock ownership plan; or
- any savings or other benefit plan established for the benefit of our employees, or any matching contribution made pursuant to the terms of any such plan, or crediting the account of any participant under any such plan by reference to the value of the common stock,

provided, that (1) during the first 24 months following the effective date, the maximum number of shares of common stock that may be issued or made subject to awards issued under any and all such plans is three percent of the aggregate number of shares of common stock outstanding immediately following completion of the conversion and this offering (including any shares issuable upon exercise of the underwriters' over-allotment option) (which three percent we refer to as the share pool), unless within such 24-month period, EIG's stockholders approve the plan or plans or amendments thereto that result in an increase in the share pool, (2) for six months after the effective date, no awards or grants of any stock options, restricted stock or other stock-based awards may be made to any senior officer of EIG or any direct or indirect subsidiary thereof, (3) during the first 24 months following the effective date, the total value of the stock options, restricted stock or other stock-based awards granted under EIG's equity and incentive plan to individuals holding the positions of Chief Executive Officer, President, Chief Operating Officer, Chief Financial Officer, General Counsel, Chief Administrative Officer or Executive Vice President of Corporate and Public Affairs (or any functional equivalent title(s) adopted in place of such titles after the adoption date) of EIG or EICN may not exceed in the aggregate 40% of the total value of the share pool, and (4) during the first 24 months following the effective date, no more than 33 1/3% of the share pool may be awarded in the aggregate in the form of awards other than options and stock appreciation rights (or similar instruments), unless, within such 24-month period, EIG's stockholders approve an amendment to the equity and incentive plan that changes such limitation.

Acquisitions of Common Stock by Directors and Executive Officers

For a period of six months following completion of the conversion and this offering, no acquisitions of any shares of common stock or options or rights to acquire any shares of our common stock, including under any benefit plan or arrangement, may be made by (1) any of our directors or senior officers, (2) any



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spouse, parent, spouse of a parent, child or spouse of a child of, or other family member living in the same household with, any of our directors or senior officers, or (3) any entity that is controlled by any director, senior officer or other such related person.

Limitations on Acquisitions of Common Stock

Under Nevada insurance law and our amended and restated articles of incorporation that will become effective on completion of the conversion, for a period of five years following the effective date of the plan of conversion or, if earlier, until such date as EIG no longer directly or indirectly owns a majority of the outstanding voting stock of EICN, no person may directly or indirectly acquire or offer to acquire in any manner beneficial ownership of five percent or more of any class of voting securities of EIG without the prior approval by the Nevada Commissioner of Insurance of an application for acquisition under Section 693A.500 of the Nevada Revised Statutes. Under Nevada insurance law, the Nevada Commissioner of Insurance may not approve an application for such acquisition unless the Commissioner finds that (1) the acquisition will not frustrate the plan of conversion as approved by our members and

the Commissioner, (2) the board of directors of EICN has approved the acquisition or extraordinary circumstances not contemplated in the plan of conversion have arisen which would warrant approval of the acquisition, and (3) the acquisition is consistent with the purpose of relevant Nevada insurance statutes to permit conversions on terms and conditions that are fair and equitable to the members eligible to receive consideration. Accordingly, as a practical matter, any person seeking to acquire us within five years after the effective date of the plan of conversion may only do so with the approval of the board of directors of EICN.

Amendments to the Plan of Conversion

The board of directors of EIG may amend our plan of conversion, prior to the approval of the plan of conversion by the members eligible to vote, by the affirmative vote of not less than two-thirds of the board and with the prior approval of the Nevada Commissioner of Insurance. The board of directors of EIG may amend our plan of conversion, after approval of the plan of conversion by the members eligible to vote, by an affirmative vote of not less than two-thirds of the board and with the prior approval of the Nevada Commissioner of Insurance, but only if the amendment is required by the Nevada Commissioner of Insurance in order for the Nevada Commissioner of Insurance to approve the plan of conversion as being fair and equitable to eligible members or in order to conform the plan of conversion to the requirements of applicable law.

The board of directors of EIG may abandon our plan of conversion at any time before the effective date by a vote of not less than two-thirds of the members of our board of directors and with the approval of the Nevada Commissioner of Insurance. The conversion must be completed within 180 days after the date of the final order issued by the Nevada Commissioner of Insurance or such later date as may be approved by the Nevada Commissioner of Insurance.

Judicial Review of Commissioner’s Final Order

Nevada law requires that the plan of conversion be approved by the Nevada Commissioner of Insurance through the issuance of both an initial order, following a public hearing, and a final order approving the application for conversion.

On August 22, 2006, we filed an application for conversion with the Nevada Commissioner of Insurance. The Nevada Commissioner of Insurance held a public hearing on the application for conversion on October 26, 2006 and issued an initial order approving the application for conversion on November 29, 2006, based upon, among other things, a determination that the plan of conversion is fair and equitable to our eligible members.

At a special meeting of our members on January 13, 2007, the plan of conversion, including the amended and restated articles of incorporation of EIG, was approved by the required votes of our members. On January 13, 2007, the Nevada Commissioner of Insurance issued a final order approving our application for conversion. Neither the initial order, nor the final order, of the Nevada Commissioner of Insurance approving the application for conversion addressed the fairness of the plan of conversion to purchasers of common stock in this offering.



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Nevada law provides that any party aggrieved by a final order of the Nevada Commissioner of Insurance approving the plan of conversion may petition for judicial review in a state district court. Under Nevada Revised Statutes 233B.035, for the purposes of this section ‘‘party’’ means ‘‘each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party, in any contested case.’’ Under Nevada law, judicial

review of a decision of the Nevada Commissioner of Insurance must be sought by initiating an action under the Nevada Administrative Procedure Act in the appropriate district court within thirty days of receipt of the final order. A successful challenge could result in injunctive relief, a modification of the plan of conversion or the Nevada Commissioner of Insurance's approval of the application for conversion being set aside. In addition, a successful challenge could result in substantial uncertainty relating to the terms and effectiveness of the plan of conversion, and an extended period of time might be required to reach a final determination. In order to successfully challenge the Nevada Commissioner of Insurance's approval of the application for conversion, a challenging party would have to sustain the burden of showing that approval was arbitrary, capricious, an abuse of discretion, made in violation of lawful procedures, clearly erroneous in view of the substantial evidence on the whole record, in violation of constitutional or statutory provisions, in excess of the statutory authority of the Nevada Commissioner of Insurance or affected by an error of law. Such an outcome would likely reduce the market price of our common stock, would likely be materially adverse to purchasers of our common stock, and would likely have a material adverse effect on our results of operations and financial condition.

We currently are not aware of any lawsuits or proceedings challenging the Nevada Commissioner of Insurance's initial or final orders approving the application for conversion. However, we cannot assure you that no such lawsuits or proceedings will be commenced.

Material U.S. Federal Income Tax Considerations of the Conversion

It is a condition to the effectiveness of the conversion that we receive, as of the effective date, an opinion of Skadden, Arps, Slate, Meagher & Flom LLP or other nationally recognized tax counsel to the company, which counsel will be entitled to rely upon representation letters in form and substance reasonably satisfactory to such counsel, substantially to the effect that:

- eligible members receiving solely common stock in exchange for their membership interests pursuant to the conversion will not recognize gain or loss for U.S. federal income tax purposes as a result of such deemed exchange, and
- the converted company will not recognize gain or loss for U.S. federal income tax purposes upon the issuance of common stock in exchange for membership interests pursuant to the conversion.



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USE OF PROCEEDS

We estimate that our net proceeds from the sale of shares of common stock in the offering will be approximately $425.2 million, or $489.0 million if the underwriters exercise their over-allotment option in full, after deducting the estimated underwriting discounts and commissions payable by us, and we estimate that the proceeds available to eligible members as cash consideration in the conversion, which equals those net procceds less estimated conversion and offering expenses, will be $408.6 million, or $472.4 million if the underwriters exercise their over-allotment option in full.

The plan of conversion requires us to use all or a portion of the net proceeds (after deducting underwriting discounts and commissions) (1) first, to pay all fees and expenses incurred by us in connection with the conversion and this offering and all cash consideration payable to all eligible members of EIG who are not eligible to receive our common

stock in the conversion (which we refer to in this prospectus collectively as the ‘‘mandatory cash requirements’’), and (2) next, to pay the cash consideration payable to eligible members of EIG who elect to receive cash instead of our common stock (which we refer to in this prospectus as the ‘‘elective cash requirements’’). Based on the number of cash elections received from our members, and assuming that the underwriters do not exercise their over-allotment option, no net proceeds will remain after all of the foregoing amounts have been paid in full. The net proceeds of any exercise of the underwriters’ over-allotment option will be used first to fund any portion of the elective cash requirements that are not funded in full by the net proceeds of the offering before such exercise, and EIG may retain and use any remaining amounts from such exercise for working capital, payment of future dividends on the common stock, repurchases of shares of common stock and other general corporate purposes.

We will use the net proceeds from the offering as follows:

- $10.5 million is estimated to be required for the cost of the non-recurring fees and expenses directly related to the conversion;
- $6.1 million is estimated to be required for the cost of the non-recurring fees and expenses directly related to this offering;
- $11.7 million is estimated to be necessary to provide consideration to members eligible solely for cash; and
- $396.9 million is estimated to be used to make elective cash payments to those eligible members that elect to receive this form of consideration in the conversion.

In the event that the net proceeds from this offering and the exercise of the underwriters’ over-allotment option (after payment of all mandatory cash requirements) are not sufficient to fund the distribution of cash consideration to all eligible members electing to receive cash instead of common stock, the remaining proceeds will be allocated pro rata among all eligible members electing to receive cash, in proportion to the number of shares allocated to such eligible members pursuant to the allocation provisions of the plan of conversion (with adjustments to prevent the creation of any odd-lots or the issuance of any fractional shares).

The maximum number of allocated shares for which cash will be available will depend on a number of factors, including the amount of net proceeds from this offering and the percentage of eligible members who have elected to receive cash.

In addition to the shares of our common stock distributed in this offering, for which we will receive cash proceeds, many eligible members entitled to receive consideration in the conversion will receive shares of our common stock distributed in connection with the conversion as consideration for extinguishment of their membership interests in us. We will not receive any proceeds from the issuance of our common stock to eligible members entitled to receive consideration in the conversion for the extinguishment of their membership interests in us.



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## CAPITALIZATION

The following table provides, as of September 30, 2006, (1) our actual consolidated capitalization and (2) our pro forma capitalization after giving effect to:

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the conversion and the issuance of an estimated 25,965,221 shares of our common stock to members entitled to receive stock compensation in the conversion;

- the receipt by us of the net proceeds from the sale of 26,750,000 shares of common stock after deducting the underwriting discounts and commissions and the estimated offering expenses payable by us; and
- the application of the net proceeds from this offering as described under ‘‘Use of Proceeds,’’

in each case as if the conversion and this offering had occurred as of September 30, 2006.

We based the pro forma information on the assumptions we have made about the number of shares of common stock and the amount of cash that will be distributed to members entitled to receive compensation in the conversion. We describe these assumptions in ‘‘Pro Forma Consolidated Financial Data.’’ You should read this table in conjunction with the pro forma consolidated financial information appearing in this prospectus.

The table below assumes that the underwriters’ option to purchase additional shares of common stock in the offering is not exercised:

| | As of September 30, 2006 | |
|---|---|---|
| | Actual | Pro Forma |
| | (in thousands) | |
| Equity: | | |
| Common stock, $0.01 par value; no shares authorized, issued or outstanding, actual; 150,000,000 shares authorized and 52,715,221 shares issued and outstanding, pro forma | $ — | $ 527 |
| Preferred stock, $0.01 par value; no shares authorized, issued or outstanding, actual; 25,000,000 shares authorized and none issued, pro forma | — | — |
| Additional paid-in capital | — | 213,493 |
| Retained earnings | 219,520 | — |
| Accumulated other comprehensive income | 53,535 | 53,535 |
| Total equity | 273,055 | 267,555 |
| Total capitalization | $ 273,055 | $ 267,555 |



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## DIVIDEND POLICY

Our board of directors has authorized the payment of a dividend of $0.06 per share of common stock per quarter to our stockholders of record beginning in the second quarter of 2007. Any determination to pay dividends will be at the discretion of our board of directors and will be dependent upon:

- the surplus and earnings of our subsidiaries and their ability to pay dividends and/or other statutorily permissible payments to us (in particular, the ability of our Nevada domiciled insurance company, EICN, to pay dividends to its immediate holding company and, in turn, the ability of that holding company to pay dividends to us);

- our results of operations and cash flows;
- our financial position and capital requirements;
- general business conditions;
- any legal, tax, regulatory and contractual restrictions on the payment of dividends; and
- any other factors our board of directors deems relevant.

There can be no assurance that we will declare and pay any dividends.

We are a holding company and, therefore, our ability to pay dividends, service our debt and meet our other obligations depends primarily on the ability of our subsidiaries, especially EICN, to pay dividends and make other statutorily permissible payments to us. Our insurance subsidiaries are subject to significant regulatory restrictions limiting their ability to declare and pay dividends. See ''Risk Factors—Risks related to our Business—We are a holding company with no direct operations, we depend on the ability of our subsidiaries to transfer funds to us to meet our obligations, and our insurance subsidiaries' ability to pay dividends to us is restricted by law.'' Nevada law limits the payment of cash dividends by EICN to its immediate holding company and, in turn, to us by providing that dividends cannot be made except from available and accumulated surplus money otherwise unrestricted (unassigned) and derived from realized net operating profits and realized and unrealized capital gains. A stock dividend may be paid out of any available surplus. At September 30, 2006, EICN had positive unassigned surplus of $23.4 million and therefore had the capability to pay a dividend of up to such amount to us without prior approval of the Nevada Commissioner of Insurance.

On October 17, 2006, the Nevada Commissioner of Insurance granted EICN permission to pay us an aggregate of up to an additional $55 million in one or more extraordinary dividends subsequent to the successful completion of this offering and before December 31, 2008. The payment of these dividends is conditioned upon the expiration of the underwriters' over-allotment option period, prior repayment of any expenses of EIG and its subsidiaries arising from the conversion and this offering, the exhaustion of any proceeds retained by EIG from this offering, maintaining the RBC total adjusted capital of EICN above a specified level on the date of declaration and payment of any particular extraordinary dividend after taking into account the effect of such dividend, and maintaining all required filings with the Nevada Division of Insurance. If EIG retains any amount of the net proceeds from this offering (including the net proceeds from the exercise of the underwriters' over-allotment option), then the entire amount of such retained proceeds must be expended before EICN may pay us any amount of the $55 million extraordinary dividend. We may use these extraordinary dividends from EICN, as well as any ordinary dividends that we may receive over time from EICN, to pay quarterly dividends to our stockholders, to repurchase our stock and/or for general corporate purposes. However, the October 17, 2006 extraordinary dividend approval prohibits us from using any such dividends to increase executive compensation.

At September 30, 2006, assuming the timing conditions described in the preceding paragraph had been satisfied, EICN would have had RBC total adjusted capital in excess of the level permitting it to pay the entire $55 million dividend to us.

Following the completion of this offering, our management intends to recommend to our board of directors that the board authorize a stock repurchase program of up to an aggregate amount of $75 million of our shares of common stock in 2007 and up to an aggregate amount of $50 million of our shares of common stock in 2008. If the plan is authorized, we may make purchases of our common stock under the

program up to such amounts from time to time, in the open market or in privately negotiated transactions, at such prices and on such terms as may be determined by our board of directors (or an authorized committee of our board of directors) out of funds legally available therefore and subject to applicable law.

The actual amount of stock repurchased, if any, will be subject to the discretion of our board of directors and will be dependent on various factors, including market conditions, legal, tax, regulatory and contractual restrictions on repurchases (including legal restrictions affecting the amount and timing of repurchase activity), our capital position, the performance of our investment portfolio, our results of operations and cash flows, our financial position and capital requirements, general business conditions, alternative potential investment opportunities available to us and any other factors our board of directors deems relevant. There can be no assurance that we will undertake any repurchases of our common stock pursuant to the program.

In addition, our ability to fund any repurchases of our common stock under the stock repurchase program will depend on the surplus and earnings of our subsidiaries and their ability to pay dividends or to advance or repay funds, and, in particular, upon the ability of our Nevada domiciled insurance company, EICN, to pay dividends to its immediate holding company and, in turn, the ability of that holding company to pay dividends to EIG. See ‘‘Risk Factors—Risks Related to Our Business’’ for a discussion of the restrictions on our subsidiaries’ ability to pay dividends.



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## SELECTED HISTORICAL CONSOLIDATED FINANCIAL AND OTHER DATA

The following selected historical consolidated financial data should be read in conjunction with ‘‘Management’s Discussion and Analysis of Financial Condition and Results of Operations’’ and the consolidated financial statements and related notes included elsewhere in this prospectus. The selected historical financial data as of September 30, 2006 and for the nine months ended September 30, 2005 and 2006, have been derived from our unaudited consolidated financial statements and related notes thereto included elsewhere in this prospectus, which include all adjustments, consisting of normal recurring adjustments, that management considers necessary for a fair presentation of our financial position and results of operations for the periods presented. The results for periods of less than a full year are not necessarily indicative of the results to be expected for any interim period or for a full year. The selected historical financial data as of December 31, 2004 and 2005 and for the years ended December 31, 2003, 2004 and 2005 have been derived from our audited consolidated financial statements and related notes thereto included elsewhere in this prospectus. The selected historical financial data as of December 31, 2003 have been derived from our audited consolidated financial statements and related notes thereto not included in this prospectus. The selected historical financial data as of and for the years ended December 31, 2001 and 2002 have been derived from our unaudited consolidated financial statements and related notes thereto not included in this prospectus. These historical results are not necessarily indicative of results to be expected in any future period.

The selected historical financial data reflect the ongoing impact of the LPT Agreement, a retroactive 100% quota share reinsurance agreement, that our Nevada insurance subsidiary assumed on January 1, 2000 in connection with our assumption of the assets, liabilities and operations of the Fund, pursuant to legislation passed in the 1999 Nevada legislature. Upon entry into the LPT Agreement, we recorded as a liability a deferred reinsurance gain which we amortize over the period during which underlying reinsured claims are paid. We record adjustments to the direct reserves subject to the LPT Agreement based on our periodic reevaluations of these reserves.

| | Year Ended December 31, | | | | | Nine Months Ended September 30, | |
|---|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2005 | 2006 |
| | (in thousands, except ratios) | | | | | | |
| Income Statement Data: | | | | | | | |
| Revenues: | | | | | | | |
| Net premiums earned | $ 126,368 | $ 180,116 | $ 298,208 | $ 410,302 | $ 438,250 | $ 331,066 | $ 300,137 |
| Net investment income | 47,421 | 36,889 | 26,297 | 42,201 | 54,416 | 39,520 | 49,715 |
| Realized (losses) gains on investments | (222) | (2,028) | 5,006 | 1,202 | (95) | (2,496) | 5,660 |
| Other income | 2,372 | (6,442) | 1,602 | 2,950 | 3,915 | 2,929 | 3,694 |
| Total revenues | 175,939 | 208,535 | 331,113 | 456,655 | 496,486 | 371,019 | 359,206 |
| Expenses: | | | | | | | |
| Losses and loss adjustment expenses | 69,670 | 113,776 | 118,123 | 229,219 | 211,688 | 208,246 | 95,745 |
| Commission expense | 15,964 | 16,919 | 56,310 | 55,369 | 46,872 | 36,859 | 36,762 |
| Underwriting and other operating expense | 37,462 | 44,345 | 56,738 | 65,492 | 69,934 | 47,726 | 59,151 |
| Total expenses | 123,096 | 175,040 | 231,171 | 350,080 | 328,494 | 292,831 | 191,658 |
| Net income before income taxes | 52,843 | 33,495 | 99,942 | 106,575 | 167,992 | 78,188 | 167,548 |
| Income taxes | 2,706 | 834 | 3,720 | 11,008 | 30,394 | 15,083 | 51,060 |
| Net income | $ 50,137 | $ 32,661 | $ 96,222 | $ 95,567 | $ 137,598 | $ 63,105 | $ 116,488 |



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| | Year Ended December 31, | | | | | Nine Months Ended September 30, | |
|---|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2005 | 2006 |
| | (in thousands, except ratios) | | | | | | |
| Selected Operating Data: | | | | | | | |
| Gross premiums written[1] | $ 120,732 | $ 197,202 | $ 337,089 | $ 437,694 | $ 458,671 | $ 351,668 | $ 310,323 |
| Net premiums written[2] | 114,763 | 186,950 | 297,649 | 417,914 | 439,721 | 336,347 | 299,471 |
| Losses and LAE ratio[3] | 55.1% | 63.2% | 39.6% | 55.9% | 48.3% | 62.9% | 31.9% |
| Commission expense ratio[4] | 12.6 | 9.4 | 18.9 | 13.5 | 10.7 | 11.1 | 12.2 |
| Underwriting and other operating expense ratio[5] | 29.6 | 24.6 | 19.0 | 16.0 | 16.0 | 14.4 | 19.7 |
| Combined ratio[6] | 97.3 | 97.2 | 77.5 | 85.4 | 75.0 | 88.4 | 63.8 |
| Net income before impact of LPT Agreement[7][8][9] | $ 26,464 | $ 11,015 | $ 46,098 | $ 72,824 | $ 93,842 | $ 47,575 | $ 101,874 |

| | As of December 31, | | | | | As of September 30, |
|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
| | (in thousands, except ratios) | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Balance Sheet Data: | | | | | | |
| Cash and cash equivalents | $ 182,955 | $ 283,351 | $ 166,213 | $ 60,414 | $ 61,083 | $ 65,965 |
| Accrued investment income | 8,075 | 6,630 | 6,190 | 12,060 | 14,296 | 16,587 |
| Premiums receivable, net | 69,304 | 60,231 | 72,201 | 73,397 | 59,811 | 51,040 |
| Total investments | 975,850 | 858,637 | 1,015,762 | 1,358,228 | 1,595,771 | 1,730,788 |
| Reinsurance recoverable on paid and unpaid losses | 1,352,225 | 1,315,240 | 1,243,085 | 1,206,612 | 1,151,166 | 1,116,334 |
| Funds held by or deposited with reinsureds | — | 38,792 | 124,271 | 134,481 | 114,175 | 104,860 |
| Deferred policy acquisition costs | 6,907 | 14,469 | 15,697 | 12,330 | 12,961 | 13,801 |
| Deferred income taxes, net | 85,667 | 82,805 | 73,152 | 72,795 | 73,152 | 64,494 |
| Property and equipment, net | 18,640 | 4,718 | 4,223 | 3,193 | 10,115 | 12,318 |
| Other assets | 14,397 | 19,043 | 17,501 | 2,176 | 1,699 | 13,516 |
| Total assets | 2,714,020 | 2,683,916 | 2,738,295 | 2,935,686 | 3,094,229 | 3,189,703 |
| Unpaid losses and loss adjustment expenses | 2,226,000 | 2,212,368 | 2,193,439 | 2,284,542 | 2,349,981 | 2,315,559 |
| Unearned premiums | 50,402 | 64,116 | 76,207 | 82,482 | 80,735 | 78,330 |
| Policyholders' dividends accrued | 7,010 | 13,297 | 3,507 | 1,294 | 880 | 1,082 |
| Commissions and premium taxes payable | 4,755 | 9,830 | 12,988 | 16,758 | 11,265 | 7,369 |
| Federal income taxes payable | 6,959 | 3,303 | 11,341 | 5,476 | 19,869 | 41,708 |
| Accounts payable and accrued expenses | 11,271 | 8,103 | 9,081 | 10,508 | 13,439 | 12,415 |
| Deferred reinsurance gain – LPT Agreement[7][8] | 600,679 | 579,033 | 528,909 | 506,166 | 462,409 | 447,795 |
| Other liabilities | 64,426 | 21,815 | 7,282 | 18,710 | 11,044 | 12,390 |
| Total liabilities | 2,971,502 | 2,911,865 | 2,842,754 | 2,925,936 | 2,949,622 | 2,916,648 |
| Total (deficit) equity | (257,482) | (227,949) | (104,459) | 9,750 | 144,607 | 273,055 |



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| | As of December 31, | | | | | As of September 30, |
|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
| | (in thousands, except ratios) | | | | | |
| Other Financial and Ratio Data: | | | | | | |
| Total equity including deferred reinsurance gain – LPT Agreement[7][8][10] | $ 343,197 | $ 351,084 | $ 424,450 | $ 515,916 | $ 607,016 | $ 720,850 |
| Total statutory surplus[11] | $ 209,797 | $ 224,234 | $ 338,656 | $ 430,676 | $ 530,612 | $ 625,852 |
| Net premiums written to total statutory surplus ratio[12] | 0.55x | 0.83x | 0.88x | 0.97x | 0.83x | |

(1)Gross premiums written is the sum of both direct premiums written and assumed premiums written before the effect of ceded reinsurance and the intercompany pooling agreement. Direct premiums written are the premiums on all policies our insurance subsidiaries have issued during the year. Assumed premiums written are premiums that our insurance subsidiaries have received from any authorized state-mandated pools and a previous fronting facility. See Note 7 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus.

(2)Net premiums written is the sum of direct premiums written and assumed premiums written less ceded premiums written. Ceded premiums written is the portion of direct premiums written that we cede to our reinsurers under our reinsurance contracts. See Note 7 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus.

(3)Losses and LAE ratio is the ratio (expressed as a percentage) of losses and LAE to net premiums earned.

(4)Commission expense ratio is the ratio (expressed as a percentage) of commission expense to net premiums earned.

(5)Underwriting and other operating expense ratio is the ratio (expressed as a percentage) of underwriting and other operating expense to net premiums earned.

(6)Combined ratio is the sum of the losses and LAE ratio, the commission expense ratio and the underwriting and other operating expense ratio.

(7)In connection with our January 1, 2000 assumption of the assets, liabilities and operations of the Fund, our Nevada insurance subsidiary assumed the Fund's rights and obligations associated with the LPT Agreement, a retroactive 100% quota share reinsurance agreement with third party reinsurers, which substantially reduced exposure to losses for pre-July 1, 1995 Nevada insured risks. Pursuant to the LPT Agreement, the Fund initially ceded $1.525 billion in liabilities for incurred but unpaid losses and LAE, which represented substantially all of the Fund's outstanding losses as of June 30, 1999 for claims with original dates of injury prior to July 1, 1995.

(8)Deferred reinsurance gain—LPT Agreement reflects the unamortized gain from our LPT Agreement. Under GAAP, this gain is deferred and is being amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE. We periodically reevaluate the remaining direct reserves subject to the LPT Agreement. Our reevaluation results in corresponding adjustments, if needed, to reserves, ceded reserves, reinsurance recoverables and the deferred reinsurance gain, with the net effect being an increase or decrease, as the case may be, to net income.

(9)We define net income before impact of LPT Agreement as net income less (i) amortization of deferred reinsurance gain—LPT Agreement and (ii) adjustments to LPT Agreement ceded reserves. Net income before impact of LPT Agreement is not a measurement of financial performance under GAAP and should not be considered in isolation or as an alternative to net income before income taxes and net income or any other measure of performance derived in accordance with GAAP.

We present net income before impact of LPT Agreement because we believe that it is an important supplemental measure of operating performance to be used by analysts, investors and other interested parties in evaluating us. The LPT Agreement was a non-recurring transaction which does not result in ongoing cash benefits and consequently we believe this presentation is useful in providing a meaningful understanding of our operating performance. In addition, we believe this non-GAAP measure, as we have defined it, is helpful to our management in identifying trends in our performance because the item excluded has limited significance in our current and ongoing operations.

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The table below shows the reconciliation of net income to net income before impact of LPT Agreement for the periods presented:

| | Year Ended December 31, | | | | | Nine Months Ended September 30, | |
|---|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2005 | 2006 |
| | (in thousands) | | | | | | |
| Net income | $50,137 | $32,661 | $96,222 | $95,567 | $137,598 | $63,105 | $116,488 |
| Less: Impact of LPT Agreement: | | | | | | | |
| Amortization of deferred reinsurance gain – LPT Agreement | 24,262 | 21,690 | 19,015 | 20,296 | 16,891 | 15,530 | 14,614 |
| Adjustment to LPT Agreement ceded reserves[a] | (589) | (44) | 31,109 | 2,447 | 26,865 | — | — |
| Net income before impact of LPT Agreement | $26,464 | $11,015 | $46,098 | $72,824 | $ 93,842 | $47,575 | $101,874 |

(a) Any adjustment to the estimated direct reserves ceded under the LPT Agreement is reflected in losses and LAE for the period during which the adjustment is determined, with a corresponding increase or decrease in net income in the period. There is a corresponding change to the reinsurance recoverables on unpaid losses as well as the deferred reinsurance gain. A cumulative adjustment to the amortization of the deferred gain is also then recognized in earnings so that the deferred reinsurance gain reflects the balance that would have existed had the revised reserves been recognized at the inception of the LPT Agreement. See Note 2 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus. Losses and LAE for the nine months ended September 30, 2005 and 2006 did not include any adjustment to LPT Agreement ceded reserves, as our reevaluation of the direct reserves subject to the LPT Agreement did not result in an adjustment for the nine months ended September 30, 2005 and 2006.

(10) We define total equity including deferred reinsurance gain—LPT Agreement as total equity plus deferred reinsurance gain—LPT Agreement. Total equity including deferred reinsurance gain—LPT Agreement is not a measurement of financial position under GAAP and should not be considered in isolation or as an alternative to total equity or any other measure of financial health derived in accordance with GAAP. We present total equity including deferred reinsurance gain—LPT Agreement because we believe that it is an important supplemental measure of financial position to be used by analysts, investors and other interested parties in evaluating us. The LPT Agreement was a non-recurring transaction and the treatment of the deferred gain does not result in ongoing cash benefits or charges to our current operations and consequently we believe this presentation is useful in providing a meaningful understanding of our financial position.

The table below shows the reconciliation of total equity to total equity including deferred reinsurance gain—LPT Agreement for the periods presented:

| | As of December 31, | | | | | As of |
|---|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 | September 30, 2006 |
| | (in thousands) | | | | | |
| Total (deficit) equity | $(257,482) | $(227,949) | $(104,459) | $ 9,750 | $144,607 | $220,055 |
| Deferred reinsurance gain – LPT Agreement | 600,679 | 579,033 | 528,909 | 506,166 | 462,409 | 447,795 |
| Total equity including deferred reinsurance gain – LPT Agreement | $ 343,197 | $ 351,084 | $ 424,450 | $515,916 | $607,016 | $720,850 |

(11) Total statutory surplus represents the total consolidated surplus of EICN, which includes its wholly-owned subsidiary ECIC, our insurance subsidiaries, prepared in accordance with the accounting practices of the NAIC, as adopted by Nevada or California, as the case may be. See Note 9 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus.

(12) Net premiums written to total statutory surplus ratio is the ratio of our insurance subsidiaries' annual net premiums written to total statutory surplus.



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## PRO FORMA CONSOLIDATED FINANCIAL DATA

The unaudited pro forma condensed consolidated financial information presented below gives effect to:

- the conversion;
- the establishment of the closed block;
- the sale of shares of common stock in this offering; and
- the application of the net proceeds from this offering as described in ''Use of Proceeds,''

as if the conversion, the establishment of the closed block and the initial public offering had occurred as of September 30, 2006, for purposes of the unaudited pro forma condensed consolidated balance sheet, and as of January 1, 2005, for purpose of the unaudited pro forma condensed consolidated statements of income for the nine months ended September 30, 2006 and the year ended December 31, 2005.

The principal assumptions used in the pro forma information are as follows:

- 50,000,000 shares of common stock are allocated to members entitled to receive consideration in the conversion in the form of common stock, cash or a combination of both;
- members entitled to receive consideration in the conversion in the form of common stock, cash or a combination of both make elections for cash such that, of the 50,000,000 shares of common stock allocated, only 25,965,221 are issued to such members in the conversion; and
- 26,750,000 shares of common stock are sold to investors in the offering at a price of $17.00 per share, the initial public offering price.

The pro forma information reflects assumed gross proceeds of $454.8 million from the issuance of the shares and assumed net proceeds from the offering of $425.2 million after deducting underwriting discounts and commissions. The pro forma information also reflects our assumption that proceeds available to eligible members as cash consideration in the conversion, which equals the net proceeds of $425.2 million less estimated conversion and offering expenses, will be $408.6 million.

The pro forma information reflects that, given the number of cash elections received from our members, we do not have an option to pay in cash a portion of the consideration to be paid to those eligible members who do not elect cash (as described under ''The Conversion—Amount and Form of Consideration—Cash Consideration to Non-Electing Members'') and therefore we will not issue additional shares of common stock to such members in the conversion in connection with any ''top up'' amount to which they could have become entitled under certain circumstances if we had such option and were to exercise it. The pro forma information also reflects that, based on the number of elections received from our members, each eligible member who elected to receive their consideration in the form of cash will receive some portion of their overall consideration in the form of common stock.

The pro forma information is based on available information and on assumptions management believes are reasonable. The pro forma information is provided for informational purposes only. This information does not necessarily indicate our consolidated financial position or our consolidated results of operations had these transactions been consummated on the dates assumed. It also does not in any way represent a projection or forecast of our consolidated financial position or consolidated results of operations for any future date or period.

The pro forma information should be read in conjunction with our consolidated financial statements and the notes to the consolidated financial statements, included elsewhere in this prospectus, and with the other information included elsewhere in this prospectus, including the information provided under ‘‘The Conversion,’’ ‘‘Management’s Discussion and Analysis of Financial Condition and Results of Operations’’ and ‘‘Business.’’



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Pro Forma Condensed Consolidated Balance Sheet

| | As of September 30, 2006 | | | |
|---|---|---|---|---|
| | Historical | Conversion | Initial Public Offering | Pro Forma |
| | (in thousands, except share and per share amounts) | | | |
| Assets: | | | | |
| Cash and cash equivalents | $ 65,965 | $ (408,591)(2)<br>(5,500)(6) | $ 408,591(4) | $ 60,465 |
| Accrued investment income | 16,587 | — | — | 16,587 |
| Premiums receivable, net | 51,040 | — | — | 51,040 |
| Total investments(1) | 1,730,788 | — | — | 1,730,788 |
| Reinsurance recoverable on paid and unpaid losses | 1,116,334 | — | — | 1,116,334 |
| Funds held by or deposited with reinsureds | 104,860 | — | — | 104,860 |
| Deferred policy acquisition costs | 13,801 | — | — | 13,801 |
| Deferred income taxes, net | 64,494 | — | — | 64,494 |
| Property and equipment, net | 12,318 | — | — | 12,318 |
| Other assets | 13,516 | — | — | 13,516 |
| Total assets | $ 3,189,703 | $ (414,091) | $ 408,591 | $ 3,184,203 |
| Liabilities: | | | | |
| Unpaid losses and loss adjustment expenses | $ 2,315,559 | $ — | $ — | $ 2,315,559 |
| Unearned premiums | 78,330 | — | — | 78,330 |
| Policyholders’ dividends accrued(1) | 1,082 | — | — | 1,082 |
| Commissions and premium taxes payable | 7,369 | — | — | 7,369 |
| Federal income taxes payable | 41,708 | — | — | 41,708 |
| Accounts payable and accrued expenses | 12,415 | — | — | 12,415 |
| Deferred reinsurance gain – LPT Agreement | 447,795 | — | — | 447,795 |
| Other liabilities | 12,390 | — | — | 12,390 |
| Total liabilities | $ 2,916,648 | $ — | $ — | $ 2,916,648 |
| Equity: | | | | |

| | | | | |
|---|---|---|---|---|
| Common Stock, $0.01 par value; 150,000,000 shares authorized; 52,715,221 shares issued and outstanding[5] | $ — | $ 500 [3]<br>(241)[2] | $ 268[4] | $ 527 |
| Additional paid-in capital | — | 213,520 [3]<br>(408,350)[2] | 408,323[4] | 213,493 |
| Retained earnings[1] | 219,520 | (5,500)[6]<br>(214,020)[3] | — | — |
| Accumulated other comprehensive income, net | 53,535 | — | — | 53,535 |
| Total equity | 273,055 | (414,091) | 408,591 | 267,555 |
| Total liabilities and equity | $ 3,189,703 | $ (414,091) | $ 408,591 | $ 3,184,203 |

See notes to pro forma condensed consolidated financial information.



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Pro Forma Condensed Consolidated Statements of Income

| | Nine Months Ended September 30, 2006 | | | |
|---|---|---|---|---|
| | Historical | Conversion | Initial Public Offering | Pro Forma |
| | (in thousands, except share and per share amounts) | | | |
| Revenues: | | | | |
| Net premiums earned | $ 300,137 | $ — | $ — | $ 300,137 |
| Net investment income | 49,715 | — | — | 49,715 |
| Realized gains on investments | 5,660 | — | — | 5,660 |
| Other income | 3,694 | — | — | 3,694 |
| Total revenues | 359,206 | — | — | 359,206 |
| Expenses: | | | | |
| Losses and loss adjustment expenses | 95,745 | — | — | 95,745 |
| Commission expense | 36,762 | — | — | 36,762 |
| Underwriting and other operating expense[1] | 59,151 | (4,995)[7] | — | 54,156 |
| Total expenses | 191,658 | (4,995) | — | 186,663 |
| Net income before income taxes | 167,548 | 4,995 | — | 172,543 |
| Income taxes | 51,060 | — | — | 51,060 |
| Net income | $ 116,488 | $ 4,995 | $ — | $ 121,483 |
| Net income per share | | | | $ 2.43 |
| Shares used in calculating net income per share[5] | | | | 50,000,000 |

See notes to pro forma condensed consolidated financial information.

| | Year Ended December 31, 2005 | | | |
|---|---|---|---|---|
| | Historical | Conversion | Initial Public Offering | Pro Forma |
| | (in thousands, except share and per share amounts) | | | |
| Revenues: | | | | |
| Net premiums earned | $ 438,250 | $ — | $ — | $ 438,250 |
| Net investment income | 54,416 | — | — | 54,416 |
| Realized gains on investments | (95) | — | — | (95) |
| Other income | 3,915 | — | — | 3,915 |
| Total revenues | 496,486 | — | — | 496,486 |
| Expenses: | | | | |
| Losses and loss adjustment expenses | 211,688 | — | — | 211,688 |
| Commission expense | 46,872 | — | — | 46,872 |
| Underwriting and other operating expense(1) | 69,934 | — | — | 69,934 |
| Total expenses | 328,494 | — | — | 328,494 |
| Net income before income taxes | 167,992 | — | — | 167,992 |
| Income taxes | 30,394 | — | — | 30,394 |
| Net income | $ 137,598 | $ — | $ — | $ 137,598 |
| Net income per share | | | | $ 2.75 |
| Shares used in calculating net income per share(5) | | | | 50,000,000 |

See notes to pro forma condensed consolidated financial information.



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Notes to Pro Forma Condensed Consolidated Financial Information

(1) Pursuant to the plan of conversion, we will cause cash and/or treasury security assets to be assigned to the closed block in an amount which is reasonably expected to be sufficient to support dividend payments to policyholders on closed block policies outstanding on the effective date of conversion. See ‘‘The Conversion—Effective Date of the Conversion.’’

We have established bookkeeping records to specifically segregate the assets in the pro forma closed block as if the closed block had been formed on January 1, 2006. These amounts are comprised of assets for the benefit of all ‘‘closed block policies.’’ The closed block will be formed on the effective date of the conversion and, accordingly, the actual assets ultimately assigned to the closed block and their carrying values will not become final until that date. It is management’s expectation that the assets of the closed block as of the effective date of the conversion will not differ materially from the assets reflected in the pro forma consolidated balance sheet. The closed block will consist solely of cash and U.S. treasury securities. Any interest or other income earned on the assets in the closed block will not form a part of the closed block, but rather will inure to the benefit of EICN.

The pro forma financial information includes summarized pro forma financial information related to the closed block at their historical gross carrying values. The pro forma condensed consolidated balance sheet as of September 30, 2006 includes (i) cash related to the closed block of $3.4 million and (ii) accrued policyholders’ dividends of $1.1 million. The pro forma condensed consolidated statements of income for the nine months ended September 30, 2006 and the year ended December 31, 2005 include dividend expense of $0.2 million and $0.9 million, respectively, in the

underwriting and other operating expense line.

Any cash proceeds received upon disposition of any closed block assets (net of reasonable and customary brokerage and other transaction expenses), will be placed into the closed block.

The closed block will terminate, and the remaining assets will revert to the benefit of EICN, from and after the calculation, declaration and payment by EICN of all dividends, if any, with respect to all closed block policies following the effective time, which we expect will be approximately 24 months following the effective time. See ‘‘The Conversion—Closed Block.’’ During this period, we will be contractually responsible for dividends pertaining to the closed block policies.

(2) Estimates based on elections received from our members, represents (in thousands):

| | |
|---|---|
| Cash to be distributed to eligible members who elect cash and to members eligible solely for cash | $408,591 |
| Common stock to be distributed to eligible members who do not elect cash | 22,756 shares |
| Common stock to be distributed to eligible members who elect cash | 3,209 shares |

The plan of conversion provides that the amount of the cash to be received by an eligible member who receives only cash will be equal to the number of shares of common stock that have been allocated to such eligible member under the allocation provisions of the plan of conversion, multiplied by the price per share at which the common stock is sold in this offering (net of any applicable withholding tax). An eligible member who receives only common stock will receive the number of shares allocated to such member under the allocation provisions of the plan of conversion.

(3) Represents the reclassification of the retained earnings of $214 million of EIG to common stock.

(4) Represents gross proceeds of $454.8 million from the sale of 26,750,000 shares of common stock at the initial public offering price of $17.00 per share, less underwriting discounts and estimated conversion and offering expenses aggregating $46.2 million.

(5) The number of shares used in the calculation of pro forma net income per share was based on elections received from our members and determined as follows:

| | Number of Shares |
|---|---|
| Assumed shares allocated to eligible members | 50,000,000 |
| Less: Shares allocated to eligible members who receive cash[(a)] | 24,034,779 |
| Estimated shares issued to eligible members[(a)] | 25,965,221 |
| Shares issued in this offering | 26,750,000 |
| Total outstanding shares of common stock | 52,715,221 |
| Less: Shares issued in this offering to fund underwriting, discounts and conversion and offering expenses[(b)] | 2,715,221 |
| Assumed number of shares used in the calculation of pro forma net income per share[(c)] | 50,000,000 |

(a) Gives effect to our estimates, based on elections received from our members, that (i) $396.9 million is used to make elective cash payments and (ii) $11.7 million is used to provide compensation to members eligible solely for cash.

(b) We estimate, based on elections received from our members, that 2,715,221 shares of common stock will be issued to cover underwriting discounts and conversion and offering expenses, representing the excess of the 26,750,000 shares of common stock we assume will be issued in this offering over the 24,034,779 shares of common stock we estimate will be issued to fund consideration to be paid to eligible members who receive cash in the conversion.

(c) These shares are included in both basic and diluted income per share calculations.

(6) The estimated additional non-recurring expenses of $5.5 million related to the conversion, assumed to be incurred as of the date of the unaudited pro forma condensed consolidated balance sheet, were charged to equity. The pro forma condensed consolidated statements of income do not reflect such non-recurring expenses because these costs are directly attributable to the conversion and are non-recurring and are thus charged to expense in the period incurred. Total estimated conversion expense excluded from pro forma statements of income was $4,995 and $0.0 for the nine months ended September 30, 2006, and for the year ended December 31, 2005, respectively.



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(7) Represents the elimination of approximately $5 million of expenses related to the conversion incurred through the nine months ended September 30, 2006, and approximately $0.0 million of expenses related to the conversion incurred through December 31, 2005. An additional $5.5 million to be incurred after the balance sheet date is assumed to be incurred in connection with the conversion as of the pro forma consolidated balance sheet date as if the conversion were to occur on that date. Conversion costs directly attributable to the conversion transaction are charged to expense in the period incurred and these costs are specifically excluded from the pro forma statements of income because they are directly attributable to the conversion, are non-recurring and are not tax deductible.

Pro Forma Supplementary Information

The unaudited pro forma supplementary information presented below was derived from the pro forma condensed consolidated financial information and the notes included in this prospectus. The pro forma supplementary information gives effect to the conversion, the establishment of the closed block and this offering as if they had occurred as of September 30, 2006, for purposes of the information derived from the pro forma condensed consolidated balance sheet, and as of January 1, 2005, for purposes of the information derived from the pro forma condensed consolidated statements of income for the nine months ended September 30, 2006 and the year ended December 31, 2005. The pro forma supplementary information is provided for informational purposes only and should not be construed to be indicative of our consolidated financial position or our consolidated results of operations had these transactions been consummated on the dates assumed, and do not in any way represent a projection or forecast of our consolidated financial position or consolidated results of operations for any future date or period. The pro forma supplementary information below should be read in conjunction with the information provided or referred to elsewhere in this section.

The information presented in the table below assumes the sale of common stock in the offering at the initial public offering price per share of $17.00. This information is intended to illustrate how the pro forma ownership would be affected by varying the number of shares issued in this offering:

Assumed Conversion Variables:

| | | | |
|---|---|---|---|
| | 1.4% | 1.4% | 1.4% |

| | | | |
|---|---|---|---|
| Percentage of total shares allocated to eligible members assumed to receive mandatory cash consideration | | | |
| Percentage of total shares allocated to eligible members assumed to elect to receive cash consideration | 53.1% | 53.1% | 53.1% |
| Percentage of total shares allocated to eligible members assumed to receive common stock | 45.5% | 45.5% | 45.5% |
| Share Information: (in thousands) | | | |
| Assumed shares to be distributed to eligible members who do not elect cash | 22,756 | 22,756 | 22,756 |
| Assumed shares to be distributed to eligible members who elect cash | 5,079 | 3,209 | 1,339 |
| Assumed shares to be distributed in this offering | 24,750 | 26,750 | 28,750 |
| Total outstanding shares of common stock | 52,585 | 52,715 | 52,845 |
| Ownership Percentage: | | | |
| Eligible members who did not elect cash | 43% | 43% | 43% |
| Eligible members who elected cash | 10% | 6% | 3% |
| Purchasers in this offering | 47% | 51% | 54% |



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Changes in the number of shares of our common stock allocated to members entitled to receive consideration in the conversion, the percentage of members electing to receive shares of our common stock in the conversion or the number of shares issued in this offering do not impact pro forma condensed consolidated net income.



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## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with the financial statements and the accompanying notes appearing elsewhere in this prospectus. In addition to historical information, the following discussion contains forward-looking statements that are subject to risks and uncertainties. Our actual results in future periods may differ from those referred to herein due to a number of factors, including the risks described in the sections entitled ''Risk Factors'' and ''Forward-Looking Statements and Associated Risks'' and elsewhere in this prospectus.

### Overview

We are a specialty provider of workers' compensation insurance focused on select small businesses engaged in low to medium hazard industries. Workers' compensation is a statutory system under which an employer is required to pay for its employees' medical, disability and vocational rehabilitation and death benefit costs for work-related injuries or

illnesses. Our business has historically targeted employers located in several western states, primarily California and Nevada. During 2005, based on net premiums written, we were the largest, seventh largest and seventeenth largest non-governmental writer of workers' compensation insurance in Nevada, California and the United States, respectively, based on net premiums written, as reported by A.M. Best.

We believe we benefit by targeting small businesses, a market that we believe to date has been characterized by fewer competitors, more attractive pricing and strong persistency when compared to the U.S. workers' compensation insurance industry in general. As a result of our disciplined underwriting standards, we believe we are able to price our policies at levels which are sustainable, competitive and profitable. Our approach to underwriting is therefore consistent with our strategy of not sacrificing profitability and stability for top-line revenue growth.

In 2005, we wrote 77.7% and 18.3% of our direct premiums written in California and Nevada, respectively. We also write business in seven other states (Arizona, Colorado, Montana, Idaho, Illinois, Texas and Utah) and are licensed to write business in six additional states (Florida, Maryland, New Mexico, New York, Oregon and Pennsylvania). We market and sell our workers' compensation insurance products through independent local and regional agents and brokers, and through our strategic distribution partners, including our principal strategic distribution partners, ADP and Wellpoint. In 2005, we wrote $126.9 million, or 27.7%, of our gross premiums written through ADP and Wellpoint. We entered Illinois in the fourth quarter of 2006 and we intend to enter Florida in the first quarter of 2007 through ADP.

We commenced operations as a private domestic mutual insurance company on January 1, 2000 when our Nevada insurance subsidiary assumed the assets, liabilities and operations of the Nevada State Industrial Insurance System. The Fund had over 80 years of workers' compensation experience in Nevada. In July 2002, we acquired the renewal rights to a book of workers' compensation insurance business, and certain other tangible and intangible assets, from Fremont, primarily comprising accounts in California and, to a lesser extent, in Idaho, Montana, Utah and Colorado. Because of the Fremont transaction, we were able to establish our important relationships and distribution agreements with ADP and Wellpoint.

In connection with our January 1, 2000 assumption of the assets, liabilities and operations of the Fund, our Nevada insurance subsidiary assumed the Fund's rights and obligations associated with the LPT Agreement, a retroactive 100% quota share reinsurance agreement with third party reinsurers, which substantially reduced exposure to losses for pre-July 1, 1995 Nevada insured risks. Pursuant to the LPT Agreement, the Fund initially ceded $1.525 billion in liabilities for the incurred but unpaid losses and LAE, which represented substantially all of the Fund's outstanding losses as of June 30, 1999 for claims with original dates of injury prior to July 1, 1995. For a more detailed description of the LPT Agreement, see ''Business—Our History'' and ''Business—Reinsurance—LPT Agreement.'' Entry into the LPT Agreement resulted in an initial deferred reinsurance gain in accordance with GAAP, and this gain is deferred and is being amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the



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amortization is reflected in losses and LAE. We periodically reevaluate the remaining direct reserves subject to the LPT Agreement. Our reevaluation results in corresponding adjustments, if needed, to reserves, ceded reserves, reinsurance recoverables and the deferred reinsurance gain, with the net effect being an increase or decrease, as the case may be, to net income. In addition, we receive a contingent commission under the LPT Agreement. Increases and decreases in the contingent commission are reflected in our commission expense. See ''Selected Historical

Consolidated Financial And Other Data,'' Note 7 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus and ''—Results of Operations'' in this ''Management's Discussion and Analysis of Financial Condition and Results of Operations.''

We operate in a single reportable segment and have three strategic business units overseeing 12 territorial offices serving the various states in which we are currently doing business.

Revenues

We derive our revenues primarily from net premiums earned, net investment income and realized gains (losses) on investments.

Net Premiums Earned. Our net premiums earned have historically been generated primarily in California and Nevada. In California, we have reduced our rates by 60% since September 2003 through January 1, 2007, principally because of competitive conditions caused by regulatory changes designed to reduce loss costs in that market. We expect that we will need to further reduce rates in California in the foreseeable future. Rates in Nevada have been stable and revenue growth is expected to be sourced from business in growing sectors in the Nevada economy, such as construction. The bundling of our products with those of our principal strategic distribution partners, ADP and Wellpoint, has contributed to the growth of our revenues because of its attractiveness to our customers. The product bundling provides customers with both convenience and some level of premium savings to the employer for both independent lines of coverage, which we believe increases the persistency of this business.

Net Investment Income and Realized Gains (Losses) on Investments. We invest our statutory surplus and the funds supporting our insurance liabilities (including unearned premiums and unpaid losses and loss adjustment expenses) in fixed maturity securities and equity securities. Net investment income includes revenue from interest and dividends on invested assets less bank service charges, custodial and portfolio management fees. Realized gains (losses) on investments include the gain or loss on a security at the time of sale compared to its original cost (equity securities) or amortized cost (fixed maturity investments). Our net investment income and realized gains and losses on investments are affected by general economic conditions. When, in the opinion of management, a decline in the fair value of an investment below its cost or amortized cost is considered to be ''other-than-temporary'' the investment's cost or amortized cost is written-down to its fair value and the amount written-down is recorded in earnings as a realized loss on investments.

On March 5, 2004, we appointed Conning Asset Management as our sole portfolio manager, replacing the previous team of seven managers. Conning follows our written investment guidelines based on strategies approved by our board of directors. Our investment strategy was revised from a total return perspective to one maximizing economic value through dynamic asset/liability management, subject to regulatory and rating agency constraints. As a result of this change, the fixed maturity securities portion of our portfolio maintains a duration target of five years, an equity allocation target of 6% and a maximum tax-exempt capacity of not more than 60% of the total fixed maturity portfolio. Decreasing the equity allocation has had the effect of decreasing surplus volatility (because under statutory accounting principles, equity securities are carried at fair value with the unrealized gains/losses charged directly to surplus in contrast to fixed income securities which are carried at amortized cost with no impact on surplus due to changes in fair value), while increasing the duration target has helped to increase the average investment income yield from 4.48% for the year ended December 31, 2004 to 4.72% for the year ended December 31, 2005. Our tax-exempt allocation is supported by our strong operating profitability and tax paying status. As this process is dynamic in nature and reevaluated at a detailed level on a quarterly basis, there could be further changes in the duration and allocation of the portfolio.

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Expenses

Our expenses consist of losses and LAE, commission expense and underwriting and other operating expense.

Losses and LAE. Losses and LAE represent our largest expense item and include claim payments made, estimates for future claim payments and changes in those estimates for current and prior periods and costs associated with investigating, defending and adjusting claims. The quality of our financial reporting depends in large part on accurately predicting our losses and LAE, which are inherently uncertain as they are estimates of the ultimate cost of individual claims based on actuarial estimation techniques. In states other than Nevada, we have a short operating history and must rely on a combination of industry experience and our specific experience to establish our best estimate of losses and LAE reserves. The interpretation of historical data can be impacted by external forces, principally legislative changes, economic fluctuations and legal trends. In recent years, we experienced lower losses and LAE in California than we anticipated due to factors such as regulatory reform designed to reduce loss costs in that market and inflation. The joint marketing of our workers' compensation insurance with Wellpoint's health insurance products also assists in reducing losses since employees make fewer workers' compensation claims because they are insured for non-work related illnesses or injuries and thus are less likely to seek treatment for a non-work related illness or injury through their employers' workers' compensation insurance carrier.

Commission Expense. Commission expense includes commissions to our agents and brokers for the premiums that they produce for us and fees in connection with fronting facilities, and is net of contingent commission related to the LPT Agreement. In July 2002, ECIC entered into a fronting facility with Clarendon Insurance Group, or Clarendon, in connection with the Fremont transaction, pursuant to which we effectively acted as a reinsurer, and provided claims servicing, in relation to new business written by Clarendon. Commissions paid to our agents and brokers and fronting fees paid to other insurers are deferred and amortized to commission expense in our statements of income as the premiums generating these commissions and fees are earned.

Underwriting and Other Operating Expense. Underwriting and other operating expense includes the costs to acquire and maintain an insurance policy (excluding commissions) consisting of premium taxes and certain other general expenses that vary with, and are primarily related to, producing new or renewal business. These acquisition costs are deferred and amortized to underwriting and other operations expense in the statement of income as the related premiums are earned. Other underwriting expenses consist of policyholder dividends and general administrative expenses such as salaries, rent, office supplies, depreciation and all other operating expenses not otherwise classified separately, and boards, bureaus and assessments of statistical agencies for policy service and administration items such as rating manuals, rating plans and experience data. The magnitude of our underwriting and other operating expense is a reflection of our operational efficiency in producing, underwriting and administering our business. We expect that our efficiency will be enhanced by the full implementation of our cost-effective and highly automated underwriting software program that allows for electronic submission and review of insurance applications, employing our underwriting standards and guidelines. However, the cost savings realized through such efficiencies may be offset, in whole or in part, by the potentially significant costs that we may incur in connection with the reporting and internal control requirements to which we will be subject under Federal securities laws and New York Stock Exchange listing requirements as a result of becoming a public company. We expect that such costs will equal approximately $2.8 million annually.

Critical Accounting Policies

Management believes it is important to understand our accounting policies in order to understand our financial statements. Management considers some of these policies to be very important to the presentation of our financial

results because they require us to make estimates and assumptions. These estimates and assumptions affect the reported amounts of our assets, liabilities, revenues and expenses and the related disclosures. Some of the estimates result from judgments that can be subjective and complex and, consequently, actual results in future periods might differ from these estimates.

Management believes that the most critical accounting policies relate to the reporting of reserves for losses and LAE, including losses that have occurred but have not been reported prior to the reporting



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date, amounts recoverable from reinsurers, recognition of premium revenue, deferred policy acquisition costs, deferred income taxes and the valuation of investments.

The following is a description of our critical accounting policies:

Reserves for Losses and Loss Adjustment Expenses

We are directly liable for losses and LAE under the terms of insurance policies our insurance subsidiaries underwrite. Significant periods of time can elapse between the occurrence of an insured loss, the reporting of the loss to the insurer and the insurer's payment of that loss. Our loss reserves are reflected in our balance sheets under the line item caption ''unpaid losses and loss adjustment expenses.'' As of September 30, 2006, our reserves for unpaid losses and LAE, net of reinsurance, were $1.2 billion.

Accounting for workers' compensation insurance requires us to estimate the liability for the expected ultimate cost of unpaid losses and LAE, referred to as loss reserves, as of a balance sheet date. We seek to provide estimates of loss reserves that equal the difference between the expected ultimate losses and LAE of all claims that have occurred as of a balance sheet date and amounts already paid. Management establishes the loss reserve based on its own analysis of emerging claims experience and environmental conditions in our markets and review of the results of various actuarial projection methods and their underlying assumptions. Our aggregate carried reserve for unpaid losses and LAE is a point estimate, which is the sum of our reserves for each accident year in which we have exposure. This aggregate carried reserve calculated by us represents our best estimate of our outstanding unpaid losses and LAE.

Maintaining the adequacy of loss reserve estimates is an inherent risk of the workers' compensation insurance business. As described below, workers' compensation claims may be paid over a long period of time. Therefore, estimating reserves for workers' compensation claims may involve more uncertainty than estimating reserves for other lines of insurance with shorter or more definite periods between occurrence of the claim and final determination of the claim amount. The amount by which estimated losses in the aggregate, measured subsequently by reference to payments and additional estimates, differ from those previously estimated for a specific time period is known as ''reserve development.'' Reserve development is unfavorable when payments for losses are made for more than the levels at which they were reserved or when subsequent estimates indicate a basis for reserve increases on open claims. In this case, the previously-estimated loss reserves are considered ''deficient.'' Reserve development is favorable when estimates of ultimate losses indicate a decrease in established reserves. In this case, the previously estimated loss reserves are considered ''redundant.'' Reserve development, whether due to an increase or decrease in the aggregate estimated losses, is reflected in operating results through an adjustment to incurred losses and LAE during the accounting period in which the development is recognized.

Although claims for which reserves are established may not be paid for several years or more, we do not discount loss reserves in our financial statements for the time value of money.

The three main components of our reserves for unpaid losses and LAE are case reserves, ‘‘incurred but not reported’’ or IBNR reserves, and LAE reserves.

Case reserves are estimates of future claim payments based upon periodic case-by-case evaluation and the judgment of our claims adjusting staff, as applied at the individual claim level. Our claims examiners determine these case reserves for reported claims on a claim-by-claim basis, based on the examiners’ judgment and experience and on our case reserving practices. We update and monitor our case reserves frequently as appropriate to reflect current information. Our case reserving practices account for the type of occupation or business, the circumstances surrounding the claim, the nature of the accident and of the resulting injury, the current medical condition and physical capabilities of the injured worker, the expected future course and cost of medical treatment and of the injured worker’s disability, the existence of dependents of the injured worker, policy provisions, the statutory benefit provisions applicable to the claim, relevant case law in the state, and potentially other factors and considerations.

IBNR is an actuarial estimate of future claim payments beyond those considered in the case reserve estimates, relating to claims arising from accidents that occurred during a particular time period on or prior to the balance sheet date. Thus, IBNR is the compilation of the estimated ultimate losses for each accident year less amounts that have been paid and case reserves. IBNR reserves, unlike case reserves,



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do not apply to a specific claim, but rather apply to the entire body of claims arising from a specific time period. IBNR primarily provides for costs due to:

- future claim payments in excess of case reserves on recorded open claims;
- additional claim payments on closed claims; and
- the cost of claims that have not yet been reported to us.

Most of our IBNR reserves relate to estimated future claim payments over and above our case reserves on recorded open claims. For workers’ compensation, most claims are reported to the employer and to the insurance company relatively quickly, and relatively small amounts are paid on claims that already have been closed (which we refer to as ‘‘reopenings’’). Consequently, late reporting and reopening of claims are a less significant part of IBNR for our insurance subsidiaries.

LAE reserves are our estimate of the diagnostic, legal, administrative and other similar expenses that we will spend in the future managing claims that have occurred on or before the balance sheet date. LAE reserves are established in the aggregate, rather than on a claim-by-claim basis.

A portion of our losses and LAE obligations are ceded to unaffiliated reinsurers. We establish our losses and LAE reserves both gross and net of ceded reinsurance. The determination of the amount of reinsurance that will be recoverable on our losses and LAE reserves includes both the reinsurance recoverable from our excess of loss reinsurance policies, as well as reinsurance recoverable under the terms of the LPT Agreement. Our reinsurance arrangements also include an intercompany pooling arrangement between EICN and ECIC, whereby each of them cedes some of its premiums, losses, and LAE to the other, but this intercompany pooling arrangement does not affect

our consolidated financial statements included elsewhere in this prospectus.

Our reserve for unpaid losses and loss adjustment expenses (gross and net), as well as the above-described main components of such reserves, as of December 31, 2003, 2004 and 2005 and September 30, 2006 were as follows:

| | December 31, 2003 | December 31, 2004 | December 31, 2005 | September 30, 2006 |
|---|---|---|---|---|
| | (in thousands) | | | |
| Case reserves | $ 814,330 | $ 777,379 | $ 772,544 | $ 755,102 |
| IBNR | 1,128,017 | 1,235,277 | 1,290,029 | 1,270,333 |
| Loss adjustment expenses | 251,092 | 271,886 | 287,408 | 290,124 |
| Gross unpaid losses and loss adjustment expenses | 2,193,439 | 2,284,542 | 2,349,981 | 2,315,559 |
| Reinsurance recoverables on unpaid losses and loss adjustment expenses, gross | 1,230,982 | 1,194,728 | 1,141,500 | 1,106,071 |
| Net unpaid losses and loss adjustment expenses | $ 962,457 | $ 1,089,814 | $ 1,208,481 | $ 1,209,488 |

Workers' compensation is considered to be a ''long-tail'' line of insurance, meaning that there can be an extended elapsed period between when a claim occurs (when the worker is injured on the job) and the final payment and resolution of the claim. As discussed above, the ''long tail'' for workers' compensation usually is not caused by a delay in the reporting of the claim. The vast majority of our workers' compensation claims are reported very promptly. The ''long tail'' for workers' compensation is caused by the fact that benefits are often paid over a long period of time, and many of the benefit amounts are difficult to determine in advance of their payment. Our obligations with respect to an injured worker may include medical care and disability-related payments for the duration of the injured worker's disability, in accordance with state workers' compensation statutes, all of which payments are considered as part of a single workers' compensation claim and are our responsibility if we were providing coverage to the employer on the date of injury. For example, in addition to medical expenses, an injured worker may receive payments for lost income associated with total or partial disability, whether temporary or permanent (i.e., the disability is expected to continue until normal retirement age or death, whichever comes first). We may also be required to make payments, often over a period of many years, to surviving



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spouses and children of workers who are killed in the course and scope of their employment. The specific components of injured workers' benefits are defined by the laws in each state.

Based on historical insurance industry experience countrywide, as reported by A.M. Best, approximately ten percent of workers' compensation claim dollars are expected to be paid more than ten years after the claim occurred. While our payout pattern likely will differ from the industry's, the industry experience illustrates the general duration of workers' compensation claims. The duration of the injured worker's disability, the course and cost of medical treatment, as well as the lifespan of dependents, are uncertain and are difficult to determine in advance. We endeavor to minimize this risk by closing claims promptly, to the extent feasible. In addition, there are no policy limits on our liability for workers' compensation claims as there are for other forms of insurance. We endeavor to mitigate this risk by purchasing reinsurance that will provide us with financial protection against the impact of very large claims and

catastrophes.

While we update and monitor our case reserves frequently as appropriate to reflect current information, it is very difficult to set precise case reserves for an individual claim due to the inherent uncertainty about the future duration of a specific injured worker's disability, the course and cost of medical care for that injured worker, and the other factors described above. Therefore, in addition to establishing case reserves on a claim-by-claim basis, we, like other workers' compensation insurance companies, establish IBNR reserves based on analyses and projections of aggregate claims data. Evaluating data on an aggregate basis eliminates some of the uncertainty associated with an individual claim. However, considerable uncertainty remains as many claims can be affected simultaneously by changes in environmental conditions such as medical technology, medical costs and medical cost inflation, economic conditions, the legal and regulatory climate, and other factors. The cost of a group of workers' compensation claims is not known with certainty until every one of the claims is ultimately closed.

Unpaid LAE is also estimated and monitored. The amount that will be spent managing claims will depend on the duration of the claims, the course of the injured worker's disability and medical treatment, the nature and degree of any disputes relating to our obligations to the claimant, the administrative and legal environment in which issues are addressed and resolved, and the cost of the company personnel and other resources that are used in the management of claims. Therefore, our LAE reserves also contribute to the overall uncertainty of our aggregate reserve for unpaid losses and LAE.

For the reasons described above, estimating reserves for workers' compensation claims may be more uncertain than estimating reserves for other lines of insurance with shorter or more definite periods between occurrence of the claim and final determination of the ultimate loss and with policy limits on liability for claim amounts. Accordingly, our reserves may prove to be inadequate to cover our actual losses and LAE.

Actuarial methodologies are used by workers' compensation insurance companies, including us, to analyze and estimate the aggregate amount of unpaid losses and LAE. As mentioned above, management considers the results of various actuarial projection methods and their underlying assumptions among other factors in establishing the reserves for unpaid losses and LAE.

Judgment is required in the actuarial estimation of unpaid losses and LAE. The judgments include the selection of methodologies to project the ultimate cost of claims; the selection of projection parameters based on historical company data, industry data, and other benchmarks; the identification and quantification of potential changes in parameters from historical levels to current and future levels due to changes in future claims development expectations caused by internal or external factors; and the weighting of differing reserve indications that result from alternative methods and assumptions. The adequacy of our ultimate loss reserves, which are based on estimates, is inherently uncertain and represents a significant risk to our business, which we attempt to mitigate through our claims management process and by monitoring and reacting to statistics relating to the cost and duration of claims. However, no assurance can be given as to whether the ultimate liability will be more or less than our loss reserve estimates.

We have retained an independent actuarial consulting firm, the Tillinghast business of Towers, Perrin, Forster and Crosby, Inc. (which we refer to in this ‘‘Management's Discussion and Analysis of Financial

Condition and Results of Operations'' as the ''consulting actuary''), to perform a comprehensive study of our losses and LAE liability semi-annually. The role of our consulting actuary as an advisor to management is to conduct sufficient analyses to produce a range of reasonable estimates, as well as a point estimate, of our unpaid losses and LAE liability, and to present those results to management. The consulting actuary also renders an opinion, as required by statutory financial reporting requirements, as to the reasonableness of our provision for unpaid losses and LAE.

For purposes of analyzing claim payment and emergence patterns and trends over time, we compile and aggregate our claims data by grouping the claims according to the year or quarter in which the claim occurred (''accident year'' or ''accident quarter''), since each such group of claims is at a different stage of progression toward the ultimate resolution and payment of those claims. The claims data is aggregated and compiled separately for different types of claims and/or claimant benefits. For our Nevada business, where a substantial detailed historical database is available from the Fund (from which our Nevada insurance subsidiary, EICN, assumed assets, liabilities and operations in 2000), these separate groupings of benefit types include death, permanent total disability, permanent partial disability, temporary disability, medical care and vocational rehabilitation. Third party subrogation recoveries are separately analyzed and projected. For other states such as California, where a substantial and detailed history on our book of business is not available, and where industry data is in a generally more aggregated form, the analyses are conducted separately for medical care benefits, and for all disability and death (also called ''indemnity'') benefits combined.

The consulting actuary selects and applies a variety of generally accepted actuarial methods to our data. The methods applied vary somewhat according to the type of claim benefit being analyzed. The primary methods utilized in recent evaluations are as follows:

Paid Bornhuetter-Ferguson Method. A method assigning partial weight to initial expected losses for each accident year and partial weight to observed paid losses. The weights assigned to the initial expected losses decrease as the accident year matures. This method is used to evaluate both our Nevada business and our other than Nevada business.

Reported Bornhuetter-Ferguson Method. A method assigning partial weight to the initial expected losses and partial weight to observed reported loss dollars (paid losses plus case reserves). The weights assigned to the initial expected losses decrease as the accident year matures. This method is used to evaluate our other than Nevada business.

Paid Development Method. A method using historical, cumulative paid losses by accident year and which develops those actual losses to estimated ultimate losses based upon the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years, adjusted as deemed appropriate for the expected effects of known changes in the workers' compensation environment, and to the extent necessary supplemented by analyses of the development of broader industry data. This method is used to evaluate both our Nevada business and our other than Nevada business. For our Nevada business, an additional variant of this method is used that involves adjusting historical data for inflation to a common cost level, and projecting future loss payments at selected inflation rates.

Reported Development Method. A method using historical, cumulative reported loss dollars by accident year and which develops those actual losses to estimated ultimate losses based upon the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years, adjusted as deemed appropriate for the expected effects of known changes in the workers' compensation environment, and to the extent necessary supplemented by analyses of the development of broader industry data. This method is used to evaluate our other than Nevada business.

Frequency-Severity Method. This method separately projects the ultimate number of claims for an accident year, based on historical claim reporting patterns, and the average cost per claim. The average cost per claim is projected both by inflation-adjusting other accident years' average cost per claim, and by observing and extrapolating based on historical patterns the per-claim cost observed to date for the accident year. This method is used to evaluate our Nevada business.

Initial Expected Loss Method. This method is used directly, and also as an input to the Bornhuetter-Ferguson methods. Initial expected losses for an accident year are based on one or more of:



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industry-benchmark losses per dollar of payroll for the mix of employment classes insured in our Nevada business, prior evaluation dates' projections of ultimate losses for the accident year, and by applying to premiums from our other than Nevada business a set of initial expected loss ratios selected after analyzing the development projections for each accident year, loss trends, statutory benefit changes, and rate changes.

Each of the methods listed above requires the selection and application of parameters and assumptions. The key parameters and assumptions are: the pattern with which our aggregate claims data will be paid or will emerge over time; claims cost inflation rates; and trends in the frequency of claims, both overall and by severity of claim. Of these, we believe the most important are the pattern with which our aggregate claims data will be paid or emerge over time and claims cost inflation rates. Each of these key items is discussed in the following paragraphs.

All of the methods depend in part on the selection of an expected pattern with which the aggregate claims data will be paid or will emerge over time. We compile, to the extent available, long-term and short-term historical data for our insurance subsidiaries, organized in a manner which provides an indication of the historical patterns with which claims have emerged and have been paid. To the extent that the historical data may not provide sufficient information about future patterns—whether due to environmental changes such as legislation or due to the small volume or short history of data for some segments of our business—benchmarks based on industry data, and forecasts made by industry rate bureaus regarding the effect of legislative benefit changes on such patterns, may be used to supplement, adjust, or replace patterns based on our subsidiaries' historical data. Actuarial judgment is required in selecting the patterns to apply to each segment of data being analyzed, and our views regarding current and future claim patterns are among the factors that enter into our establishment of the losses and LAE reserves at each balance sheet date. When short-term averages or external rate bureau analyses indicate that the claims patterns are changing from historical company or industry patterns, that new or forecasted information typically is factored into the methodologies gradually, so that the projections will not overreact to what may turn out to be a temporary or unwarranted assumption about changes in patterns. When new claims emergence or payment patterns have appeared in the actual data repeatedly over multiple evaluations, those new patterns are given greater weight in the selection process. Because some claims are paid over many years, the selection of claim emergence and payment patterns involves judgmentally estimating the manner in which recently-occurring claims will develop many years or decades in the future, and it is likely that the actual development that will occur in the distant future could differ substantially from historical patterns or current projections. The current projections would differ if different claims development patterns were selected for each benefit type.

The expected pattern with which the aggregate claims data will be paid or will emerge over time is expressed as a percentage of ultimate losses that remain to be paid at each evaluation date for each accident year. A lower estimate of the percentage of aggregate claims dollars remaining to be paid, when applied in the actuarial methods, produces a lower dollar estimate of the unpaid loss. For example, the estimated percentage of losses expected to be paid more than 36 months after the start of the accident year has been as follows for the benefit types that account for most of our loss reserves:

| | As of December 31, | | | As of June 30, |
|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006[1] |
| Nevada: | | | | |
| Medical | 44 – 46% | 43 – 45% | 44 – 45% | 45 – 48% |
| Permanent total disability | 99 | 99 | 99 | 99 |
| Fatals | 92 | 92 | 92 | 92 |
| Permanent partial disability | 28 | 29 | 34 | 33 |
| States other than Nevada: | | | | |
| Medical | 41 | 51 | 52 | 55 |
| Indemnity | 41 | 42 | 41 | 35 |

(1) The consulting actuary's reserve analysis is only completed at June 30 and December 31 of each year. The consulting actuary's reserve report for December 31, 2006 is, as of the date hereof, not in final form. Therefore, only information as of June 30, 2006 is reflected above.



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These benefit types account for approximately 77% of our total losses and LAE reserves. The payment patterns are reviewed each year based on the observed recent and long-term patterns in our own historical data, recent and long-term patterns in industry data, and analyses of potential changes in patterns resulting from major legislative benefit changes. The changes in the payment patterns for Nevada are the result of these regular reviews of our historical data and updating of the actuarial judgments involved in selecting expected payment patterns. A range is shown for medical because multiple methods are used to select medical payment patterns in Nevada. The changes in the payment patterns used in states other than Nevada were significantly influenced by analysis of the anticipated effects of the 2003 California legislation relating to workers' compensation benefits, as well as observations of our early experience as it emerged of claims experience subsequent to the enactment of that legislation. At each reserve evaluation, as more claims experience has emerged subsequent to that legislation, the post-legislative claims experience has been given increasing judgmental weight in the actuarial selection of expected future payment patterns. The actual payout pattern for the aggregate claims associated with an accident year will not be known until decades later, when all the claims are closed.

Several of the methods also involve adjusting historical data for inflation. For these methods, the inflation rates used in the analysis are judgmentally selected based on historical year-to-year movements in the cost of claims observed in the data of our insurance subsidiaries and in industry-wide data, as well as on broader inflation indices. The results of these methods would differ if different inflation rates were selected.

In projections using June 30, 2006 data, the methods that use explicit medical cost inflation assumptions included medical cost inflation assumptions ranging from 3.5% to 9%. Corresponding medical cost inflation assumptions in prior projections were 5.5% to 9% at December 31, 2005, 4.5% to 8% at December 31, 2004, and 2.5% to 8% at December 31, 2003. The selection of medical cost inflation assumptions for use in the actuarial methodologies in each of these analyses has been based on observed recent and longer-term historical medical cost inflation in our claims data and in the economy more generally. The rate of medical cost inflation as reflected in our historical medical payments per claim has averaged approximately 6.5% over the past five years, and approximately 6% over the past ten years. The rate of medical cost inflation in the general U.S. economy, as measured by the consumer price index—medical care, has averaged approximately 4.5% over the past five years, and approximately 4% over the past ten years.

Several of the actuarial methods depend on assumptions about claim frequency trends. We examine the overall movement in the frequency, or number, of claims, as well as movements in the relative frequency of claims of different severities, as measured by the proportions of claims receiving different levels of benefit payments. Judgments about the relative proportion of claims from the most recent years that ultimately will receive benefit payments at different levels are based on historical and recent levels and movements of our claim counts and form the basis for the projection of the ultimate number of claims that will receive benefits payments for each benefit type.

The methods employed for each segment of claims data, and the relative weight accorded to each method, vary depending on the nature of the claims segment and on the age of the claims. For claim or benefit types that pay out for many years, and for the most recent accident periods in which the claims are relatively immature, more weight is given to methods that tend to produce more stable results by including initial expected losses or claim severities that are estimated in part by reliance on other accident years adjusted for inflation and other factors to the level of the accident year being analyzed.

All of the actuarial methods described for our Nevada business are used for each of the different benefit types that are analyzed. For benefit types in which most of the loss dollars are paid out within several years of the claim occurrence (temporary total disability, permanent partial disability and vocational rehabilitation) the selection of ultimate losses for all but the most recent three to five accident years is based primarily on the results of the paid development method due to the expectation that ultimate losses for the mature years will be highly correlated with the losses that have been paid to date, and the selection of estimated ultimate losses for the least mature accident years gives consideration to the results of all of the methods with the paid development method given the least consideration in the least mature (that is, most recent) accident year. For benefit types that typically involve payments



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extending over many years or even decades (permanent total disability, dependent benefits on fatal claims, and medical care benefits) the ultimate losses for the most recent ten or more accident years may not be highly correlated with the amounts paid to date and thus the selection of estimated ultimate losses for these recent accident years is based primarily on the frequency-severity method, the paid Bornhuetter-Ferguson method and the initial expected loss method, all of which rely in part on long-term observations regarding the average cost of claims of the particular benefit type and, in the case of medical care benefits, also allow for explicit medical cost inflation assumptions. In states other than Nevada, the paid Bornhuetter-Ferguson, reported Bornhuetter-Ferguson, paid development, and reported development methods are used for all benefit types. All of our claims experience in these states is immature; as a result, the results of the Bornhuetter-Ferguson methods are given greater weight in the selection of estimated ultimate losses because these methods do not produce results that are as highly leveraged off our immature paid or reported claims experience.

For EICN, the analysis of unpaid loss is conducted on claims data prior to recognition of reinsurance, and a separate projection is made of future reinsurance recoveries, based on our reinsurance arrangements, and an analysis of large claims experience both for EICN and as reflected in industry-based benchmarks. The projections prior to recognition of reinsurance provide the basis for estimating gross-of-reinsurance unpaid losses, from which the projection of future reinsurance recoveries is subtracted to estimate net-of-reinsurance unpaid losses. For ECIC, the analysis of unpaid loss is conducted on claims data net of reinsurance, and a separate projection is made of future reinsurance recoveries, which is added to the estimated net-of-reinsurance unpaid losses to estimate gross-of-reinsurance unpaid losses. Finally, reinsurance pooling arrangements between EICN and ECIC are explicitly recognized by applying factors that reflect the portion of unpaid losses that EICN cedes to ECIC and that ECIC cedes to EICN.

Management and the consulting actuary separately analyze LAE and estimate unpaid LAE. This analysis relies primarily on examining the relationship between the aggregate amount that has been spent on LAE historically, as compared with the dollar volume of claims activity for the corresponding historical calendar periods. Based on these historical relationships, and judgmental estimates of the extent to which claim management resources are focused more intensely on the initial handling of claims than on the ongoing management of claims, the consulting actuary selects a range of future LAE estimates that is a function of the projected future claim payment activity. The portion of unpaid LAE that will be recoverable from reinsurers is estimated based on the contractual reinsurance terms.

Based on the results of the analyses conducted, the stability of the historical data, and the characteristics of the various claims segments analyzed, the consulting actuary selects a range of estimated unpaid losses and LAE and a point estimate of unpaid losses and LAE, for presentation to our management. The selected range is intended to represent the range in which it is most likely that the ultimate losses will fall. This range is narrower than the range of indications produced by the individual methods applied because it is not likely, although it is possible, that the high or low result will emerge for every state, benefit type and accident year. The consulting actuary's point estimate of unpaid losses and LAE is based on a judgmental selection for each benefit type from within the range of results indicated by the different actuarial methods.

Management formally establishes loss reserves for financial statement purposes on a quarterly basis. In doing so, we make reference to the most current analyses of our consulting actuary (which are conducted at June 30 and December 31 each year), including a review of the assumptions and the results of the various actuarial methods used by the consulting actuary; we monitor our claim reporting and claim payment activity, and consider the claim frequency and claim severity trends indicated by the claim activity as well as any emerging claims environment or operational issues that may indicate changing trends; we monitor workers' compensation industry trends as reported by industry rate bureaus, in the media, and other similar sources; we monitor our recoveries from reinsurance and from other third party sources; we monitor the expenses of managing claims; and we monitor the characteristics of the business we have written in the current quarter and prior quarters, including characteristics such as geographical location, type of business, size of accounts, historical claims experience, and pricing levels.

The case reserve component of our loss reserves is updated on an ongoing basis, in the normal course of claims examiners managing individual claims, and this component of our loss reserves at quarter-end is the sum of the case reserve as of quarter-end on each individual open claim.



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Management determines the IBNR and LAE components of our loss reserves by establishing a point in the range of the consulting actuary's most recent analysis of unpaid losses and LAE, which may be at a prior quarter-end, with the selection of the point based on management's own view of recent and future claim emergence patterns, payment patterns, and trends, including: our view of the markets in which we are operating, including environmental conditions and changes in those markets; the characteristics of the business we have written in recent quarters; recent and pending recoveries from reinsurance; our view of trends in the future costs of managing claims; and other similar considerations as we view relevant.

If the consulting actuary's most recent analysis is at a prior quarter-end, to bring our loss reserves to the current quarter-end, we then make an appropriate adjustment to our reserve for unpaid losses and LAE to account for our business activities in the most recent quarter, reflecting the actual claim payment and case reserving activity, newly reported claims, actual LAE expenditures, reinsurance and other recoveries, and the expected ultimate volume and

cost of claims and LAE on the business we insured in the quarter.

The aggregate carried reserve calculated by management represents our best estimate of our outstanding unpaid losses and LAE. We believe that we should be conservative in our reserving practices due to the long tail nature of workers' compensation claims payouts, the susceptibility of those future payments to unpredictable external forces such as medical cost inflation and other economic conditions, and the actual variability of loss reserve adequacy that we have observed in the workers' compensation insurance industry.

At December 31, 2003, management's best estimate of unpaid losses and LAE was $962.5 million, which was $73.5 million above the consulting actuary's point estimate. In establishing its best estimate at December 31, 2003, management considered (i) the consulting actuary's assumptions, point estimate and range, (ii) the inherent uncertainty of workers' compensation unpaid loss and LAE liabilities and (iii) the particular uncertainties associated with (a) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California legislature in late 2003 and the future regulatory implementation of those reforms, (b) the uncertain cost of administering claims (LAE) in the reformed California system, (c) adverse development on California workers' compensation losses and LAE reserves that some insurance companies had reported in recent years, (d) the limited historical experience of ECIC following its acquisition from Fremont in 2002 as a base for projecting future loss development, and (e) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following premium and market share reductions following EICN's commencement of operations in 2000. Management did not quantify a specific loss reserve increment for each of these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at December 31, 2003 in light of the historical data, the consulting actuary's assumptions, point estimate and range, current facts and circumstances, and the sources of uncertainty identified by management. Management's best estimate of unpaid loss and LAE at December 31, 2003 fell within the consulting actuary's range of estimates. The increase in management's best estimate relative to the consulting actuary's point estimate from December 31, 2002 to December 31, 2003 increased losses and LAE expense incurred by $3.3 million for the year ended December 31, 2003.

At December 31, 2004, management's best estimate of unpaid losses and LAE was $1,089.8 million, which was $89.7 million above the consulting actuary's point estimate. In establishing its best estimate at December 31, 2004, management considered (i) the consulting actuary's assumptions, point estimate and range, (ii) the inherent uncertainty of workers' compensation unpaid loss and LAE liabilities, and (iii) the particular uncertainties associated with (a) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California legislature in late 2003 and the regulatory implementation of those reforms, the effects of which will become clear over a number of years, (b) the uncertain cost of administering claims (LAE) in the reformed California system, (c) the rapid growth in the volume of our business in California, (d) the limited historical experience of ECIC to use as a base for projecting future loss development, (e) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following premium and market share reductions following EICN's commencement of operations in 2000, (f) recent changes in EICN's claim department processes, controls, and management, and (g) the legislative adoption of new guidelines for determining



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claimant permanent partial disability ratings in Nevada after October 2003. Management did not quantify a specific loss reserve increment for each of these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at December 31,

2004 in light of the historical data, the consulting actuary's assumptions, point estimate and range, current facts and circumstances, and the sources of uncertainty identified by management. Management's best estimate of unpaid losses and LAE at December 31, 2004 fell within the consulting actuary's range of estimates. The increase in management's best estimate relative to the consulting actuary's point estimate from December 31, 2003 to December 31, 2004 increased losses and LAE expense incurred by $16.2 million for the year ended December 31, 2004.

At December 31, 2005, management's best estimate of unpaid losses and LAE was $1,208.5 million, which was $84.3 million above the consulting actuary's point estimate. In establishing its best estimate at December 31, 2005, management considered (i) the consulting actuary's assumptions, point estimate and range, (ii) the inherent uncertainty of workers' compensation unpaid losses and LAE liabilities, and (iii) the particular uncertainties associated with (a) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California legislature in late 2003 and the future regulatory implementation of those reforms, the effects of which will become clear over a number of years, but which our initial experience indicated were emerging favorably, (b) the uncertain cost of administering claims (LAE) in the reformed California system, (c) the potential for legislative and/or judicial reversal of the California reforms, (d) the rapid growth in the volume of our business in California, (e) the limited but growing historical experience of ECIC to use as a base for projecting future loss development, (f) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following continued premium and market share reductions, (g) recent changes in EICN's claim department processes, controls and management, (h) the legislative adoption of future cost-of-living increases on permanent total disability payments on injuries occurring January 1, 2005 and after in Nevada, and (i) the degree to which our reinsurance protection will absorb our unanticipated development on years subject to the LPT Agreement and on large claims in excess of our current reinsurance retention. Management did not quantify a specific loss reserve increment for each of these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at December 31, 2005 in light of the historical data, the consulting actuary's assumptions, point estimate and range, current facts and circumstances, and the sources of uncertainty identified by management. Management's best estimate of unpaid losses and LAE at December 31, 2005 fell within the consulting actuary's range of estimates. The decrease in management's best estimate relative to the consulting actuary's point estimate from December 31, 2004 to December 31, 2005 decreased losses and LAE expense incurred by $5.4 million for the year ended December 31, 2005.

At June 30, 2006, management's best estimate of unpaid losses and LAE was $1,276.2 million, which was $155.2 million above the consulting actuary's point estimate at June 30, 2006. The consulting actuary's range of reasonable estimates and point estimate were not yet available at the time management established its best estimate. In establishing its best estimate at June 30, 2006, management considered (i) the consulting actuary's December 31, 2005 assumptions, point estimate and range, (ii) the volume and perceived profitability trends of the business during the first two quarters of 2006, and the volume of claims activity during the first two quarters of 2006, (iii) the inherent uncertainty of workers' compensation unpaid losses and LAE liabilities, and (iv) the particular uncertainties associated with (a) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California legislature in late 2003 and the future regulatory implementation of those reforms, the effects of which will become clear over a number of years, but which our initial experience indicated were emerging favorably, (b) the uncertain cost of administering claims (LAE) in the reformed California system, (c) the potential for legislative and/or judicial reversal of the California reforms, (d) the rapid growth in the volume of our business in California, (e) the limited but growing historical experience of ECIC to use as a base for projecting future loss development, (f) prior years' changes in EICN claim department processes, controls and management and (g) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following continued premium and market share reductions. Management did not quantify a specific loss reserve increment for each of

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these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at June 30, 2006 in light of the historical data, the consulting actuary's assumptions, point estimate and range from prior analyses, current facts and circumstances, and the sources of uncertainty identified by management. Management's best estimate of unpaid losses and LAE at June 30, 2006 fell within the consulting actuary's range of estimates, although such range was not available at the time management established its best estimate. The results of the consulting actuary's study and determination of a point estimate at June 30, 2006 indicated that management's best estimate had increased by $70.9 million relative to the consulting actuary's point estimate from December 31, 2005 to June 30, 2006. The key factor contributing to the increase in management's best estimate relative to the consulting actuary's point estimate at June 30, 2006, was the continuing favorable emergence and payment levels in our subsidiaries' claims experience, relative to prior projections. In projecting future losses and LAE to estimate the unpaid losses and LAE at an evaluation date, we and the consulting actuary must make judgments as to whether this favorable claims experience will persist in the future, or whether the emergence and payment of claims will revert to historical levels. At June 30, 2006, the consulting actuary gave greater weight in some of the actuarial methodologies to the continuing favorable emergence of losses than management did. During the three months ended September 30, 2006, management reviewed and evaluated the consulting actuary's analysis, reviewed and evaluated the continuing favorable emergence and payment levels in our subsidiaries' claims experience, and made a corresponding adjustment to its reserve for unpaid losses as of September 30, 2006, including a $68.9 million reduction from June 30, 2006 to September 30, 2006 in our estimate of losses and LAE for prior accident years. Subsequent to September 30, 2006 and in connection with a fourth quarter review of unpaid losses and LAE reserves, including our review and evaluation of the consulting actuary's analysis, management identified continuing favorable emergence and payment levels, and made a corresponding downward adjustment of $20 million in our reserves for unpaid losses and LAE which primarily related to prior accident years as of December 31, 2006.

At September 30, 2006, management's best estimate of unpaid losses and LAE was $1,209.5 million. The consulting actuary does not perform an analysis at March 31 or September 30 of each year. In establishing its best estimate at September 30, 2006, management considered (i) the consulting actuary's June 30, 2006 assumptions, point estimate and range, (ii) the volume and perceived profitability trends of the business during the quarter, and the volume of claims activity during the quarter, (iii) the inherent uncertainty of workers' compensation unpaid losses and LAE liabilities, and (iv) the particular uncertainties associated with (a) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California legislature in late 2003 and the regulatory implementation of those reforms, many effects of which will become clear over a number of years, but which our initial experience continues to indicate are emerging favorably, (b) the uncertain cost of administering claims (LAE) in the reformed California system, (c) the rapid growth in the volume of our business in California, (d) the limited but growing historical experience of ECIC to use as a base for projecting future loss development, (e) prior years' changes in EICN's claim department processes, controls and management, and (f) the degree of movement observed in our prior years' projections of losses and LAE. Management established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at September 30, 2006 in light of the historical data, the consulting actuary's assumptions, point estimate and range from prior analyses, current facts and circumstances, and the sources of uncertainty identified by management.

The table below provides the consulting actuary's range of estimated liabilities for unpaid losses and LAE and our carried reserves at the dates shown:

| | As of December 31, | | | As of June |
|---|---|---|---|---|
| 2003 | 2004 | 2005 | 30, | |

| | (in thousands) | | | 2006[1] |
|---|---|---|---|---|
| Low end of consulting actuary's range | $ 827,913 | $ 931,409 | $ 1,024,849 | $ 1,029,451 |
| Carried reserves | 962,457 | 1,089,814 | 1,208,481 | 1,276,205 |
| High end of consulting actuary's range | 1,000,079 | 1,146,754 | 1,293,028 | 1,287,612 |

(1)The consulting actuary's reserve analysis is only completed at June 30 and December 31 of each year. The consulting actuary's reserve report for December 31, 2006 is, as of the date hereof, not in final form. Therefore, only information as of June 30, 2006 is reflected above.



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Loss reserves are our estimates at a given point in time of our ultimate liability for the cost of claims and of the cost of managing those claims, and are inherently uncertain. It is likely that the ultimate liability will differ from our estimates, perhaps significantly. Such estimates are not precise in that, among other things, they are based on predictions of future claim emergence and payment patterns and estimates of future trends in claim frequency and claim cost. These estimates assume that the claim emergence and payment patterns, claim inflation and claim frequency trend assumptions implicitly built into our selected loss reserve will continue into the future. Unexpected changes in claim cost inflation can occur through changes in general inflationary trends, changes in medical technology and procedures, changes in wage levels and general economic conditions and changes in legal theories of compensability of injured workers and their dependents. Furthermore, future costs can be influenced by changes in workers' compensation statutory benefit structure, and benefit administration and delivery.

In applying actuarial techniques, judgment is required to determine the relevance of historical claim emergence and payment patterns and other historical data, external industry benchmark data, information about current economic conditions such as inflation, and recent changes in environmental conditions such as legislation as well as company operational changes in selecting parameters for those techniques under current facts and circumstances. Judgment also is required in selecting from among the loss indications produced by the several actuarial techniques that are used. From evaluation to evaluation, it often is appropriate to adjust the various methods and parameters used in the projection of losses to reflect the expected or estimated effect of such factors. Even after such adjustments, ultimate liability may exceed or be less than the revised estimates.

Estimates of ultimate losses and LAE may change from one balance sheet date to the next when actual claim payment or changes in individual case reserve estimates between those dates differs from the expected claim activity underlying the prior loss reserve estimate, and when actual LAE expenditures differ from expected expenditure levels underlying the prior LAE reserve estimate. As actual losses and LAE expenditures occur during a calendar period, they replace the portion of prior estimates of unpaid losses and LAE that relate to that period. In addition, the parameters used in the various methods and the relative weight accorded to the results of the different actuarial methods, all of which require judgment, may change as a result of observing that the actual pattern of expenditures differs from prior expectations, as well as based on new industry wide data and benchmarks derived from that data, when available. The parameters and weights used in estimating ultimate losses may also change when external conditions—such as the statutory benefit structures or the manner in which it is being interpreted and administered, or inflation—differ from expectations underlying the prior estimate of ultimate losses, and when the effects of factors related to internal operations differ from expectations underlying the prior estimate of ultimate losses.

Each of the actuarial methods used in the analysis and estimation of unpaid losses and LAE depend in part on the selection of an expected pattern with which the aggregate claims data will be paid or will emerge over time, and the

assumption that this expected pattern will prevail into the future. We select relevant patterns as part of the periodic review and projection of unpaid losses and LAE. In selecting these patterns, we examine, to the extent available, long-term and short-term historical data for our insurance subsidiaries, benchmarks based on industry data and forecasts made by industry rate bureaus regarding the effect of legislative benefit changes on such patterns. Actuarial judgment is required in selecting the patterns to apply to each segment of data being analyzed.

Management judgment is required in selecting the amount of the loss reserve to record on our financial statements. Management reviews the various actuarial projections, the assumptions underlying those projections, the range of indications produced by the actuarial methods and the actual long-term and recent emergence and payment of claims. Management also considers the environmental conditions in which the insurance subsidiaries are doing business. In addition, management considers the degree of uncertainty associated with the estimates based on the degree of change that has occurred or is occurring in the environment and in operations.



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The following table provides a reconciliation of the beginning and ending loss reserves for each of 2003, 2004 and 2005 and the nine months ended September 30, 2006 on a GAAP basis:

| | Year Ended December 31, | | | Nine Months Ended September 30, |
|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 |
| | (in thousands) | | | |
| Unpaid losses and LAE at beginning of period | $ 2,212,368 | $ 2,193,439 | $ 2,284,542 | $ 2,349,981 |
| Less reinsurance recoverables excluding bad debt allowance on unpaid losses | 1,304,042 | 1,230,982 | 1,194,728 | 1,141,500 |
| Net unpaid losses and LAE at beginning of the period | 908,326 | 962,457 | 1,089,814 | 1,208,481 |
| Losses and LAE, net of reinsurance, incurred in: | | | | |
| Current year | 237,456 | 289,544 | 333,497 | 192,080 |
| Prior years | (69,209) | (37,582) | (78,053) | (81,721) |
| Total net losses and LAE incurred | 168,247 | 251,962 | 255,444 | 110,359 |
| Deduct payments for losses and LAE, net of reinsurance related to: | | | | |
| Current year | 33,169 | 33,475 | 40,116 | 25,556 |
| Prior years | 80,947 | 91,130 | 96,661 | 83,796 |
| Total net payments for losses and LAE during the current period | 114,116 | 124,605 | 136,777 | 109,352 |
| Ending unpaid losses and LAE, net of reinsurance | 962,457 | 1,089,814 | 1,208,481 | 1,209,488 |
| Reinsurance recoverable excluding bad debt allowance on unpaid losses and LAE | 1,230,982 | 1,194,728 | 1,141,500 | 1,106,071 |
| Ending unpaid losses and LAE, gross of reinsurance | $ 2,193,439 | $ 2,284,542 | $ 2,349,981 | $ 2,315,559 |

Estimates of incurred losses and LAE attributable to insured events of prior years decreased due to continued favorable development in such prior accident years (actual losses and LAE paid and current projections of unpaid losses and LAE were less than we originally anticipated). The reduction in the liability for unpaid losses and LAE was $69.2 million, $37.6 million, $78.1 million and $81.7 million for the years ended December 31, 2003, 2004 and 2005 and the nine months ended September 30, 2006, respectively.

The major sources of this favorable development have been: actual paid losses have been less than expected, recalibration of selected patterns of claims emergence and claim payment used in the projection of future loss payment, and LAE in our Nevada business has been less than expected. However, this favorable development has been partially offset by the fact that LAE in our California business has been greater than expected. LAE parameters used to project future LAE expenditures have been adjusted in response to the actual observed levels of LAE. These sources of development are discussed in the following paragraphs.

In California, in particular, where our operations began on July 1, 2002, the consulting actuary's and management's initial expectations of the ultimate level of losses and patterns of loss emergence and loss payment necessarily were based on benchmarks derived from analyses of historical insurance industry data in California, as no historical data from our California insurance subsidiary existed and, although some historical data was available for the prior years for some of the market segments we entered in California, that data was limited as to the number of loss reserve evaluation points available. The industry-based benchmarks were adjusted judgmentally for the anticipated impact of significant environmental changes, specifically the enactment of major changes to the statutory workers' compensation benefit structure and the manner in which claims are administered and adjudicated in California. The actual emergence and payment of claims by our California insurance subsidiary has been more favorable than those initial expectations, due at least in part, we believe, to the impact of enactment of the major changes in the California environment. Other insurance companies writing California workers'



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compensation insurance have also experienced emergence and payment of claims more favorable than anticipated. At each evaluation date, the projected claim activity underlying the prior loss reserves has been replaced by the actual claim activity, and the expectation of future emergence and payment of California claims underlying the actuarial projections has been reevaluated periodically based both on our insurance subsidiaries' emerging experience and on updating the benchmarks that are derived from observing and analyzing the insurance industry data for California workers' compensation. The change in incurred losses and LAE attributable to prior years as a result of business outside Nevada, predominantly California, was $(25.1) million, $(11.9) million, $48.2 million and $86.0 million for the years ended December 31, 2003, 2004, 2005 and the nine months ended September 30, 2006, respectively. In states other than California and Nevada, our insurance subsidiaries' operations are new and represent a minor portion of our loss reserves. Losses for those states are included with the California losses for purposes of estimating future loss development.

In Nevada, we have compiled a lengthy history of workers' compensation claims payment patterns based on the business of the Fund and EICN, but the emergence and payment of claims in recent years has been more favorable than in the long-term history in Nevada with the Fund. The expected patterns of claim payment and emergence used in the projection of our ultimate claims payments are based on both the long-term and the short-term historical data. In recent evaluations, the selection of claim projection patterns has relied more heavily on the patterns observed in the short-term historical data, as recent years' claims have continued to emerge in a manner consistent with that short-term

historical data. Also, at each evaluation date, the projected claim payments underlying the prior loss reserves were replaced by the actual claim payment activity that occurred during the calendar year. The change in incurred losses and LAE attributable to prior years attributable to business in Nevada was $94.3 million, $49.5 million, $29.9 million and $(4.3) million for the years ended December 31, 2003, 2004, 2005 and the nine months ended September 30, 2006, respectively.

The estimate of the future cost of handling claims, or LAE, depends primarily on examining the relationship between the aggregate amount that has been spent on LAE historically, as compared with the dollar volume of claims activity for the corresponding historical periods. For our insurance subsidiaries' business in Nevada, as a result of operational improvements and reductions in staff count to align with the current and anticipated volume of business in the state, our expenditures on LAE in recent years have been lower than historical levels. As these operational improvements and staffing levels have been reflected in the actual emerging LAE expenditures and in the projection of future LAE, the estimates of future LAE have reduced. For our insurance subsidiaries' operations in California, initial expectations of LAE when operations commenced in California were based on the assumptions used by management in pricing the California business, and on some limited historical data for the market segments we were entering. As our operations in California have matured, and as data relating to our subsidiaries' and industry claim handling expenses reflective of the new workers' compensation benefit environment in California have become available, the expectations of LAE underlying the projection of future LAE have been adjusted to reflect that actual costs of administering claims has been greater than the initial expectations. This has resulted in an increase in the projected future cost of administering California claims. The changes in our estimates of the cost of future LAE in California and Nevada are included in the California and Nevada development results cited in the preceding two paragraphs.

We review our loss reserves each quarter and, as mentioned earlier, our consulting actuary assists our review by performing an actuarial analysis and projection of unpaid losses and LAE twice each year. We may adjust our reserves based on the results of our reviews and these adjustments could be significant. If we change our estimates, these changes are reflected in our results of operations during the period in which they are made. Our actual claims and LAE experience and emergence in recent years has been more favorable than anticipated in prior evaluations, although our California LAE has been higher than initially anticipated. Our insurance subsidiaries have been operating in a period of dramatically changing environmental conditions in our major markets, entry into new markets, and operational changes. During periods characterized by such changes, at each evaluation, the consulting actuary and management must make judgments as to the relative weight to accord to long-term historical and recent company data, external data, evaluations of environmental changes, and other factors in selecting the methods to use in projecting ultimate losses and LAE, the parameters to incorporate in those methods, and the relative



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weights to accord to the different projection indications. Since the loss reserves are providing for claim payments that will emerge over many years, if management's projections and loss reserves were established in a manner that reacted quickly to each new emerging trend in the data or in the environment, there would be a high likelihood that future adjustments, perhaps significant in magnitude, would be required to correct for trends that turned out not to be persistent. At each balance sheet evaluation, some losses and LAE projection methods have produced indications above the loss reserve selected by management, and some losses and LAE projection methods have produced indications lower than the loss reserve selected by management. At each evaluation, management has given weight to new data, recent indications, and evaluations of environmental conditions and changes that implicitly reflect management's expectation as to the degree to which the future will resemble the most recent information and most recent changes, as compared with long-term claim payment, claim emergence, and claim cost inflation patterns. As

patterns and trends recur consistently over a period of quarters or years, management gives greater implicit weight to these recent patterns and trends in developing our future expectations. In our view, in establishing loss reserves at each historical balance sheet date, we have used prudent judgment in balancing long-term data and recent information.

It is likely that ultimate losses and LAE will differ from the loss reserves recorded in our September 30, 2006 balance sheet. Actual losses and LAE payments could be greater or less than our projections, perhaps significantly. The following paragraphs discuss several potential sources of such deviations, and illustrate their potential magnitudes.

In recent years, emerging claims costs and claim emergence and payment patterns have improved dramatically. The largest driver of this improvement has been California reform. As we observe continuing improvement in development, we have given significant weight to this emerging trend in projecting and selecting estimated ultimate losses and LAE. The amount of weight to allocate between the emerging trend and historical benchmark patterns is judgmental. We have given significant weight to the emerging trends in our selection of loss reserves as of September 30, 2006. However, recent data points from our business in California, as well as from insurance industry experience for California workers' compensation, indicate emergence patterns more favorable than those implicitly underlying our loss reserves. If future emergence matches those more favorable patterns, our current loss reserves could develop favorably over time. If future claims emergence more closely resembles long term historical industry patterns, then our current loss reserves could develop unfavorably over time. In Nevada, we have seen a significant improvement in claims emergence and claims payment patterns in recent years, and have given these improved patterns significant weight in establishing loss reserves for our Nevada business. If future emergence in Nevada more closely resembles long term historical patterns of the predecessor Fund, then our current loss reserves could develop unfavorably over time.

For loss adjustment expense, particularly in Nevada, our projections assume a long term cost of managing claims that is greater than the recent levels of LAE produced by our insurance subsidiaries' current operating model, but is less than the levels of LAE expended in more distant historical past years by our insurance subsidiaries and by the Fund. Future changes in claims operations, while not currently planned or contemplated, could result in future actual LAE and future projections of LAE that may differ from current estimates. If future levels of LAE match recent levels of LAE, our current reserves for LAE could develop favorably over time; if future levels of LAE return to older historical levels, our current reserves for LAE could develop unfavorably over time.

Some of the actuarial projection methods also rely on a selection of claim cost inflation rates. If actual claim cost inflation differs from expectations underlying prior selections, or as environmental conditions in the states in which we do business or in the economy generally change, we will reevaluate and may change the selected claim cost inflation rate in future analyses. Such a change in assumptions would cause the results of some of the actuarial methods to change from one evaluation to the next. The ultimate cost of our claims will depend in part on actual inflation rates in future years, which may differ from the inflation expectations implicit in our loss reserves.

More than 45% of our claims payments during the three years ended December 31, 2005 has related to medical care for injured workers. The utilization and cost of medical services in the future is a significant source of uncertainty in the establishment of loss reserves for workers' compensation. In recent



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years, our medical costs per claim have been rising at an average rate of approximately 6.5% per year. Some of our projection methods include explicit assumptions about future medical claim cost inflation. In projections using June

30, 2006 data, the methods that use explicit medical cost inflation assumptions have included medical claim cost inflation assumptions ranging from 3.5% to 9%. Future medical claim cost inflation, whether due to changing medical technology, utilization of medical services, or the cost of medical services, could fall outside this range. We are not able to state the rate of medical cost inflation that is assumed in our loss reserves because our loss reserves are established based on reviewing the results of actuarial methods that do not contain explicit medical claim cost inflation rates, as well as methods that do contain explicit medical claim cost inflation rates. However, because medical care will be provided over many years, and in some cases decades, to the injured workers who have open claims, the pace of medical claim cost inflation has a significant impact on our ultimate claim payments. For example, if the rate of medical claim cost inflation increases by 1% above the inflation rate that is implicitly included in the loss reserves at September 30, 2006, we estimate that future medical costs over the lifetime of the current claims would increase by approximately $60 million for EICN and by approximately $15 million for ECIC, on a net-of-reinsurance basis.

Our reserve estimates reflect expected increases in the costs of contested claims and assume we will not be subject to losses from significant new legal liability theories. While it is not possible to predict the impact of changes in this environment, if expanded legal theories of liability emerge, our IBNR claims may differ substantially from our IBNR reserves. Our reserve estimates assume that there will not be significant future changes in the regulatory and legislative environment. The impact of potential changes in the regulatory or legislative environment is difficult to quantify in the absence of specific, significant new regulation or legislation. In the event of significant new regulation or legislation, we will attempt to quantify its impact on our business.

The range of potential variation of actual ultimate losses and LAE from our current reserve for unpaid losses and LAE is difficult to estimate because of the significant environmental changes in our markets, particularly California, and because our insurance subsidiaries do not have a lengthy operating history in our markets outside Nevada.

Furthermore, the methodologies we currently employ in evaluating our losses and LAE liability do not allow us to quantify the sensitivity of our losses and LAE reserves to reasonably likely changes in the underlying key assumptions. Management will refine its methodologies to provide for such capability in the future.

The range of estimates of unpaid losses and LAE produced by our consulting actuary and the foregoing discussion of the impact of medical cost inflation provide some indication of the potential variability of future losses and LAE payments. If the actual unpaid losses and LAE were at the high or the low end of the consulting actuary's range (see the table above), the impact on our financial results would be as follows:

| | December 31, 2003 | December 31, 2004 | December 31, 2005 | June 30, 2006[1] |
|---|---|---|---|---|
| | (in thousands) | | | |
| Increase (decrease) in reserves: | | | | |
| At low end of range | $ (134,544) | $ (158,404) | $ (183,630) | $ (246,755) |
| At high end of range | 37,622 | 56,941 | 84,549 | 11,406 |
| Increase (decrease) in equity and net income: | | | | |
| At low end of range | $ 87,454 | $ 102,963 | $ 119,360 | $ 160,391 |
| At high end of range | (24,454) | (37,012) | (54,957) | (7,414) |

(1) The consulting actuary's reserve analysis is only completed at June 30 and December 31 of each year. The consulting actuary's reserve report for December 31, 2006 is, as of the date hereof, not in final form. Therefore, only information as of June 30, 2006 is reflected above.

However, the consulting actuary's range represents an estimated range in which it is most likely that the ultimate losses and LAE will fall, based on the consulting actuary's review of the results of the various methodologies and parameters used by the consulting actuary in the projection of losses and LAE. Each



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different actuarial method may produce a different indication of unpaid losses and LAE because each method relies in different ways on assumptions about the future. For example, the loss development methods are based on an assumption that the selected pattern of emergence or payout of claims will recur in the future, the frequency-severity method is based on an assumption that the most recent year's ultimate average cost per claim can be estimated by inflation-adjusting other accident years' average cost per claim and by extrapolating based on historical patterns the per-claim cost observed to date for the accident year, the initial expected loss method assumes that the ultimate losses can be estimated based on the payroll of workers insured by us and a benchmark loss cost per payroll or as a percentage of premium, and the Bornhuetter-Ferguson methods rely on a combination of these assumptions. Actual losses are affected by a more complex combination of forces and dynamics than any one model or methodology can represent, and each actuarial methodology is an approximation of these complex forces and dynamics, and thus each different actuarial methodology may produce different indications of unpaid losses and LAE. None of the methods is designed or intended to produce an indication that is systematically higher or lower than the other methods. Nonetheless, at any given evaluation date, some of the actuarial projection methods produce indications outside this range, and the selection of reasonable alternative methods or reasonable alternative parameters in the actuarial projection process would produce an even wider range of potential outcomes, both above and below the range shown. Accordingly, we believe that the range of potential outcomes is considerably wider than the consulting actuary's estimated range of the most likely outcomes. The magnitude of adjustments to prior years' reserves for unpaid losses and LAE reserves that we have made at December 31, 2003, 2004 and 2005 and at September 30, 2006, decreases of $69.2 million, $37.6 million, $78.1 million, and $81.7 million respectively—also illustrate that changes in estimates of unpaid losses and LAE can be significant from year to year. We do not have a basis for anticipating that actual future payments of losses and LAE are more likely to be either greater than or less than the reserve for unpaid losses and LAE on our current balance sheet.

Reinsurance Recoverables

Reinsurance recoverables represent: (1) amounts currently due from reinsurers on paid losses and LAE, (2) amounts recoverable from reinsurers on case basis estimates of reported losses and (3) amounts recoverable from reinsurers on actuarial estimates of IBNR for losses and LAE. These recoverables, by necessity, are based upon our current estimates of the underlying losses and LAE, and are reported on our balance sheet separately as assets, as reinsurance does not relieve us of our legal liability to policyholders. We bear credit risk with respect to the reinsurers, which can be significant considering that some of the unpaid losses and LAE remain outstanding for an extended period of time. Reinsurers might refuse or fail to pay losses that we cede to them, or they might delay payment. We are required to pay losses even if a reinsurer refuses or fails to meet its obligations under the applicable reinsurance agreement. We continually monitor the financial condition and rating agency ratings of our reinsurers. We require reinsurers that are not admitted reinsurers in Nevada and California (where EICN and ECIC, respectively, are domiciled) to collateralize their share of the unearned premiums and unpaid loss reserves in order that our insurance subsidiaries receive credit for reinsurance on their statutory financial statements. Since our inception in 2000, no material amounts due from reinsurers have been written-off as uncollectible and, based on this experience, we believe that amounts currently reflected in our consolidated financial statements will similarly require no material prospective adjustment.

Under the LPT Agreement, the Fund initially ceded $1.525 billion in liabilities for the incurred but unpaid losses and LAE related to claims incurred prior to July 1, 1995, for consideration of $775 million in cash. As of September 30, 2006, the estimated remaining liabilities subject to the LPT Agreement were approximately $1 billion. Losses and LAE paid with respect to the LPT Agreement totaled approximately $353.6 million at September 30, 2006.

We account for the LPT Agreement in accordance with FAS 113, Accounting and Reporting for Reinsurance of Short-Term and Long-Duration Contracts, and as retroactive reinsurance. Upon entry into the LPT Agreement, an initial deferred reinsurance gain was recorded as a liability in our consolidated balance sheet. This gain is being amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE. In addition, we are entitled to receive a contingent commission under the LPT Agreement. The contingent commission is estimated based on both actual



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results to date and projections of expected ultimate losses under the LPT Agreement. Increases and decreases in the estimated contingent commission are reflected in our commission expense in the year that the estimate is revised.

Recognition of Premium Revenue

All premium revenue is recognized over the period of the contract in proportion to the amount of insurance protection provided. The insurance premiums we charge are billed to our policyholders either annually or under various installment plans based on the estimated annual premium under the policy terms. At the end of the policy term, payroll-based premium audits are performed on substantially all policyholder accounts to determine net premiums earned for the policy year. Earned but unbilled premiums include estimated future audit premiums. Estimates of future audit premiums are based on our historical experience. These estimates are subject to changes in policyholders' payrolls due to growth, economic conditions and seasonality. The estimates are continually reviewed and adjusted as necessary as experience develops or new information becomes known. Any such adjustments are included in current operations. Since our inception in 2000, there have been no material adjustments of our accrual for earned but unbilled premium and, based on this experience, and, although considerable variability is inherent in such estimates, we believe that amounts currently reflected in our consolidated financial statements will similarly require no material prospective adjustment.

Deferred Policy Acquisition Costs

We defer commission expenses, premium taxes and certain marketing, sales, underwriting and safety costs that vary with and are primarily related to the acquisition of insurance policies. These acquisition costs are capitalized and charged to expense ratably as premiums are earned. In calculating deferred policy acquisition costs, these costs are limited to their estimated realizable value, which gives effect to the premiums to be earned, anticipated losses and settlement expenses and certain other costs we expect to incur as the premiums are earned, less related net investment income. Judgments as to the ultimate recoverability of these deferred policy acquisition costs are highly dependent upon estimated future profitability of unearned premiums. If the unearned premiums were less than our expected claims and expenses after considering investment income, we would reduce the deferred costs. Estimated future profitability is calculated as the sum of expected claims costs, claims adjustment expenses, expected dividends to policyholders, unamortized acquisition costs and policy maintenance costs relative to the related unearned premiums. Any deficiency would first be recognized by charging any unamortized acquisition costs to expense to the extent

required to eliminate the deficiency. If the deficiency were greater than unamortized acquisition costs, a liability would be accrued for the excess deficiency. We do consider anticipated investment income when determining if a deficiency exists. Since our inception in 2000, we have had no write-offs due to such deficiencies and, based on this experience, we believe that amounts currently reflected in our consolidated financial statements will similarly require no material prospective adjustment.

Deferred Income Taxes

We use the liability method of accounting for income taxes. Under this method, deferred income tax assets and liabilities are recognized for the future tax consequences attributed to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities resulting from a tax rate change impacts our net income or loss in the reporting period that includes the enactment date of the tax rate change. Our income tax returns are subject to audit by the Internal Revenue Service and various state tax authorities. Significant disputes may arise with these tax authorities involving issues of the timing and amount of deductions and allocations of income among various tax jurisdictions because of differing interpretations of tax laws and regulations. We periodically evaluate our exposures associated with tax filing positions. Although we believe our positions comply with applicable laws, we record liabilities based upon estimates of the ultimate outcomes of these matters.

In assessing whether our deferred tax assets will be realized, management considers whether it is more likely than not that we will generate future taxable income during the periods in which those





temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, tax planning strategies and projected future taxable income in making this assessment. If necessary, we establish a valuation allowance to reduce the deferred tax assets to the amounts that are more likely than not to be realized.

Valuation of Investments

Our investments in fixed maturity investments and equity securities are classified as available-for-sale and are reported at fair value with unrealized gains and losses excluded from earnings and reported in a separate component of equity, net of deferred taxes as a component of accumulated other comprehensive income.

Realized gains and losses on sales of investments are recognized in operations on the specific identification basis.

Impairment of Investment Securities. Impairment of an investment security results in a reduction of the carrying value of the security and the realization of a loss when the fair value of the security declines below our cost or amortized cost, as applicable, for the security and the impairment is deemed to be other-than-temporary. We regularly review our investment portfolio to evaluate the necessity of recording impairment losses for other-than-temporary declines in the fair value of our investments. We consider various factors in determining if a decline in the fair value of an individual security is other-than-temporary. Some of the factors we consider include:

- how long and by how much the fair value of the security has been below its cost;

- the financial condition and near-term prospects of the issuer of the security, including any specific events that may affect its operations or earnings;
- our intent and ability to keep the security for a sufficient time period for it to recover its value;
- any downgrades of the security by a rating agency; and
- any reduction or elimination of dividends, or nonpayment of scheduled interest payments.

The amount of any write-downs is determined by the difference between cost or amortized cost of the investment and its fair value at the time the other-than-temporary decline was identified. See ‘‘Business—Investments.’’ Since our inception in 2000, we have recorded write-downs for investment securities considered to be other-than-temporarily impaired of an aggregate of $5.4 million.

Measurement of Results

We evaluate our operations by using the following key measures:

Gross Premiums Written. Gross premiums written is the sum of both direct premiums written and assumed premiums written before the effect of ceded reinsurance and the intercompany pooling agreement. Direct premiums written represent the premiums on all policies our insurance subsidiaries have issued during the year. Assumed premiums written represent the premiums that our insurance subsidiaries have received from an authorized state-mandated pool or under previous fronting facilities. The primary fronting facility was between ECIC and Clarendon and that arrangement is now in run-off. We use gross premiums written, which excludes the impact of premiums ceded to reinsurers, as a measure of the underlying growth of our insurance business from period to period.

Net Premiums Written. Net premiums written is the sum of direct premiums written and assumed premiums written less ceded premiums written. Ceded premiums written is the portion of direct premiums written that we cede to our reinsurers under our reinsurance contracts. We use net premiums written, primarily in relation to gross premiums written, to measure the amount of business retained after cession to reinsurers.

Net Premiums Earned. Net premiums earned represents that portion of net premiums written equal to the expired portion of the time for which insurance protection was provided during the financial year and is recognized as revenue. Net premiums earned are used to calculate the losses and LAE, underwriting and other operating expense and combined ratios, as indicated below.



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Losses and LAE Ratio. The losses and LAE ratio is a measure of the underwriting profitability of an insurance company’s business. Expressed as a percentage, this is the ratio of losses and LAE to net premiums earned.

Like many insurance companies, we analyze our losses and LAE ratios on a calendar year basis and on an accident year basis. A calendar year losses and LAE ratio is calculated by dividing the losses and LAE incurred during the calendar year, regardless of when the underlying insured event occurred, by the net premiums earned during that calendar year. The calendar year losses and LAE ratio includes changes made during the calendar year in reserves for losses and LAE established for insured events occurring in the current and prior periods. A calendar year losses and LAE ratio is calculated using premiums and losses and LAE that are net of amounts ceded to reinsurers.

An accident year losses and LAE ratio, or losses and LAE for insured events that occurred during a particular year

divided by the premiums earned for the year, is calculated by dividing the losses and LAE, regardless of when such losses and LAE are incurred, for insured events that occurred during a particular year by the net premiums earned for that year. An accident year losses and LAE ratio is calculated using premiums and losses and LAE that are net of amounts ceded to reinsurers. An accident year losses and LAE ratio for a particular year can decrease or increase when recalculated in subsequent periods as the reserves established for insured events occurring during that year develop favorably or unfavorably, respectively, whereas the calendar year losses and LAE ratio for a particular year will not change in future periods. This ratio is an operating ratio based on our statutory financial statements and is not derived from our GAAP financial information.

We analyze our calendar year losses and LAE ratio to measure our profitability in a particular year and to evaluate the adequacy of our premium rates charged in a particular year to cover expected losses and LAE from all periods, including development (whether favorable or unfavorable) of reserves established in prior periods. In contrast, we analyze our accident year losses and LAE ratios to evaluate our underwriting performance and the adequacy of the premium rates we charged in a particular year in relation to ultimate losses and LAE from insured events occurring during that year.

While calendar year losses and LAE ratios are useful in measuring our profitability, we believe that accident year losses and LAE ratios are more meaningful in evaluating our underwriting performance for any particular year because an accident year losses and LAE ratio better matches premium and loss information. Furthermore, accident year losses and LAE ratios are not distorted by adjustments to reserves established for insured events that occurred in other periods, which may be influenced by factors that are not generally applicable to all years. The losses and LAE ratios provided in this prospectus are calendar year losses and LAE ratios, except where they are expressly identified as accident year losses and LAE ratios.

Commission Expense Ratio. Commission expense ratio is the ratio (expressed as a percentage) of commission expense to net premiums earned and measures the effectiveness of compensating agents and brokers for the business we have underwritten.

Underwriting and Other Operating Expense Ratio. The underwriting and other operating expense ratio is the ratio (expressed as a percentage) of underwriting and other operating expense to net premiums earned, and measures an insurance company’s operational efficiency in producing, underwriting and administering its insurance business.

Combined Ratio. The combined ratio is a measure used in the property and casualty insurance business to show the profitability of an insurer’s underwriting, and it represents the percentage of each premium dollar spent on claims and expenses. The combined ratio is the sum of the losses and LAE ratio, the commission expense ratio and the underwriting and other operating expense ratio. The losses and LAE ratio, commission expense ratio and underwriting and other operating expense ratio express the relationship between losses and LAE, commissions and underwriting and other operating expenses (including policyholder dividends), respectively, to net premiums earned. When the combined ratio is below 100%, an insurance company experiences underwriting gain, meaning that claims payments, the cost of settling claims, commissions and underwriting expenses are less than premiums collected. If the combined ratio is at or above 100%, an insurance company cannot be profitable without investment income, and may not be profitable if investment income is insufficient. Companies with lower combined ratios than their peers generally experience greater profitability.

Results of Operations

Nine Months Ended September 30, 2006 Compared to Nine Months Ended September 30, 2005

| | Nine Months Ended September 30, | | Increase (Decrease) Nine Months Ended September 30, 2006 over Nine Months Ended September 30, 2005 | Increase (Decrease) Nine Months Ended September 30, 2006 over Nine Months Ended September 30, 2005 |
|---|---|---|---|---|
| | 2005 | 2006 | | |
| | (in thousands, except percentages and percentage points) | | | |
| Selected Financial Data: | | | | |
| Gross premiums written | $ 351,668 | $ 310,323 | $ (41,345) | (11.8)% |
| Net premiums written | 336,347 | 299,471 | (36,876) | (11.0) |
| Net premiums earned | 331,066 | 300,137 | (30,929) | (9.3) |
| Net investment income | 39,520 | 49,715 | 10,195 | 25.8 |
| Realized (losses) gains on investments | (2,496) | 5,660 | 8,156 | (326.8) |
| Other income | 2,929 | 3,694 | 765 | 26.1 |
| Total revenue | 371,019 | 359,206 | (11,813) | (3.2) |
| Losses and LAE | 208,246 | 95,745 | (112,501) | (54.0) |
| Commission expense | 36,859 | 36,762 | (97) | (0.3) |
| Underwriting and other operating expense | 47,726 | 59,151 | 11,425 | 23.9 |
| Income taxes | 15,083 | 51,060 | 35,977 | 238.5 |
| Net income | $ 63,105 | $ 116,488 | $ 53,383 | 84.6% |
| Selected Operating Data: | | | | |
| Losses and LAE ratio | 62.9% | 31.9% | (31.0) | n/a |
| Commission expense ratio | 11.1 | 12.2 | 1.1 | n/a |
| Underwriting and other operating expense ratio | 14.4 | 19.7 | 5.3 | n/a |
| Combined ratio | 88.4 | 63.8 | (24.6) | n/a |
| Net income before impact of LPT Agreement[1] | $ 47,575 | $ 101,874 | $ 54,299 | 114.1% |

(1) We define net income before impact of LPT Agreement as net income less (i) amortization of deferred reinsurance gain—LPT Agreement and (ii) adjustments to LPT Agreement ceded reserves. Deferred reinsurance gain—LPT Agreement reflects the unamortized gain from our LPT Agreement. Under GAAP, this gain is deferred and is being amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE. We periodically reevaluate the remaining direct reserves subject to the LPT Agreement. Our reevaluation results in corresponding adjustments, if needed, to reserves, ceded reserves, reinsurance recoverables and the deferred reinsurance gain, with the net effect being an increase or decrease, as the case may be, to net income. Net income before impact of LPT Agreement is not a measurement of financial performance under GAAP and should not be considered in isolation or as an alternative to net income before income taxes and net income or any other measure of performance derived in accordance with GAAP.

We present net income before impact of LPT Agreement because we believe that it is an important supplemental measure of operating performance to be used by analysts, investors and other interested parties in evaluating us. The LPT Agreement was a non-recurring transaction which does not result in ongoing cash benefits and consequently we believe this presentation is useful in

providing a meaningful understanding of our operating performance. In addition, we believe this non-GAAP measure, as we have defined it, is helpful to our management in identifying trends in our performance because the excluded item has limited significance in our current and ongoing operations.



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The table below shows the reconciliation of net income to net income before impact of LPT Agreement for the periods presented:

| | Nine Months Ended September 30, | |
|---|---|---|
| | 2005 | 2006 |
| | (in thousands) | |
| Net income | $63,105 | $116,488 |
| Less: Impact of LPT Agreement: | | |
| Amortization of deferred reinsurance gain – LPT Agreement | 15,530 | 14,614 |
| Adjustment to LPT Agreement ceded reserves[(a)] | — | — |
| Net income before impact of LPT Agreement | $47,575 | $101,874 |

(a) Any adjustment to the estimated direct reserves ceded under the LPT Agreement is reflected in losses and LAE for the period during which the adjustment is determined, with a corresponding increase or decrease in net income in the period. There is a corresponding change to the reinsurance recoverables on unpaid losses as well as the deferred reinsurance gain. A cumulative adjustment to the amortization of the deferred gain is also then recognized in earnings so that the deferred reinsurance gain reflects the balance that would have existed had the revised reserves been recognized at the inception of the LPT Agreement. See Note 2 in the Notes to our Consolidated Financial Statements which are included elsewhere in this prospectus. Losses and LAE for the nine months ended September 30, 2005 and 2006 did not include any adjustment to LPT Agreement ceded reserves, as our reevaluation of the direct reserves subject to the LPT Agreement did not result in an adjustment for the nine months ended September 30, 2005 and 2006.

Gross premiums written decreased $41.4 million, or 11.8%, to $310.3 million for the nine months ended September 30, 2006 from $351.7 million for the nine months ended September 30, 2005. The decrease in gross premiums written was primarily due to additional rate decreases in California. The average in force policy premium at September 30, 2006 decreased 20% to $12,259 from $15,331 at September 30, 2005. The impact of such rate reductions was partially offset by an increase of approximately 2,100 in the in force policy count in the nine months ended September 30, 2006, as compared to the nine-month period ended September 30, 2005. The majority of the in force policy count increase was attributable to growth in the number of policies written through our strategic distribution partnerships.

Net premiums written decreased $36.8 million, or 11.0%, to $299.5 million for the nine months ended September 30, 2006 from $336.3 million for the nine months ended September 30, 2005. The decrease was primarily attributable to a $41.4 million decrease in gross premiums written. This decrease was partially offset by a relative reduction in ceded premiums. Ceded premiums for the nine months ended September 30, 2006 totaled $10.9 million, or 3.5%, of gross premiums written as compared to $15.3 million, or 4.4%, of gross premiums written for the nine months ended September 30, 2005. The decrease in ceded premiums was due to favorable market trends in reinsurance rates and an increase in the amount of risk we retained under the excess of loss reinsurance treaty, which is reset on June 30 of

each year.

Net premiums earned decreased $31.0 million, or 9.3%, to $300.1 million for the nine months ended September 30, 2006 from $331.1 million for the nine months ended September 30, 2005. The decrease in net premiums earned was primarily the result of the decrease in net premiums written for the nine months ended September 30, 2006 as compared to the nine months ended September 30, 2005.

Net investment income increased $10.2 million, or 25.8%, to $49.7 million for the nine months ended September 30, 2006 from $39.5 million for the nine months ended September 30, 2005. The yield on invested assets increased by approximately 0.32 of a percentage point to 4.87%, and our invested assets increased $223.0 million as a result of investment yield and increased operating income. Invested assets increased in the nine months ended September 30, 2006, as a result of favorable net cash flows and an increase in the fair market value of equity securities.

Realized (losses) gains on investments increased $8.2 million due to a gain of $5.7 million for the nine months ended September 30, 2006 from a loss of $(2.5) million for the nine months ended September 30, 2005. The gain was primarily attributable to a $6.1 million gain on the sale of equity securities holdings, the market value of which was influenced by the acquisition or merger of the issuers of such securities during the nine months ended September 30, 2006, offset by an other-than-temporary



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impairment adjustment of $0.4 million. The realized capital loss for the nine months ended September 30, 2005 includes an other-than-temporary impairment adjustment of $2.1 million.

Other income increased $0.8 million, or 26.1%, to $3.7 million for the nine months ended September 30, 2006 from $2.9 million for the nine months ended September 30, 2005. The increase in other income was primarily attributable to interest income derived from the assets held in trust related to our fronting facility with Clarendon.

Losses and LAE decreased $112.5 million, or 54.0%, to $95.7 million for the nine months ended September 30, 2006 from $208.2 million for the nine months ended September 30, 2005. Losses and LAE were 31.9% and 62.9% of net premiums earned for the nine months ended September 30, 2006 and the nine months ended September 30, 2005, respectively. The majority of the decrease was due to an 11.7% downward adjustment in our current accident year loss estimate from 75.7% for the nine months ended September 30, 2005 to 64.0% for the nine months ended September 30, 2006. This adjustment was made after we observed several successive quarters of reduced loss development in California due to the impact of regulatory reforms designed to control loss costs.

The favorable prior accident year reserve development totaled $81.7 million for the nine months ended September 30, 2006, compared to $26.5 million for the nine months ended September 30, 2005. Losses and LAE include amortization of deferred reinsurance gain—LPT Agreement of $14.6 million and $15.5 million in the nine months ended September 30, 2006 and 2005, respectively. Excluding these two items, losses and LAE would have been $192.0 million and $250.3 million, or 64.0% and 75.6% of net premiums earned, for the nine months ended September 30, 2006 and 2005, respectively. Losses and LAE for the nine months ended September 30, 2005 and 2006 did not include any adjustment to LPT Agreement ceded reserves, as our reevaluation of the direct reserves subject to the LPT Agreement did not result in an adjustment for the nine months ended September 30, 2006 and 2005.

Commission expense decreased $0.1 million, or 0.3%, to $36.8 million for the nine months ended September 30, 2006 from $36.9 million for the nine months ended September 30, 2005. Commission expense was 12.2% and 11.1% of net premiums earned for the nine months ended September 30, 2006 and the nine months ended September 30, 2005, respectively. The commission expense decrease was primarily the result of the decrease in net premiums earned for the nine months ended September 30, 2006 as compared to the nine months ended September 30, 2005, as discussed above. The decrease in net earned premiums resulted in a $3.3 million decrease in commission expense for the nine months ended September 30, 2006 compared to the nine months ended September 30, 2005. In July 2006, we increased our commission rates from 10% to 12.5% for policies that met certain requirements. The increase in commission rates resulted in an increase of $2.5 million in commission expense for the nine months ended September 30, 2006 compared to the nine months ended September 30, 2005. The commission expense decrease was also partially offset by a $0.7 million refund of the calendar year 2004 Nevada assigned risk market servicing carrier allowance recorded in the nine months ended September 30, 2005.

Underwriting and other operating expense increased $11.5 million, or 23.9%, to $59.2 million for the nine months ended September 30, 2006 from $47.7 million for the nine months ended September 30, 2005. The increase is composed of a $4.7 million increase in payroll and employee benefits, a $2.3 million increase in technology maintenance and depreciation and a $4.8 million increase in professional fees for the nine months ended September 30, 2006 as compared to the nine months ended September 30, 2005. The increase in payroll and employee benefits were incurred to support increased in force policy count. The increase of professional fees was due to the incurrence of expenses related to the conversion, Sarbanes-Oxley Act compliance and internal audit expenses.

Income taxes increased $36.0 million, or 238.5%, to $51.1 million for the nine months ended September 30, 2006 from $15.1 million for the nine months ended September 30, 2005. The increase in income taxes was primarily due to an $89.4 million increase in pre-tax income for the nine months ended September 30, 2006.

Net income increased $53.4 million, or 84.6%, to $116.5 million for the nine months ended September 30, 2006 from $63.1 million for the nine months ended September 30, 2005. The net income increase was primarily due to the decrease in our losses and LAE relative to net premiums earned, as



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measured by the calendar year losses and LAE ratio decline of 31.0 percentage points, from 62.9%, as of September 30, 2005, to 31.9% as of September 30, 2006. This decline was primarily due to redundancies in loss reserves for prior accident years arising because of the impact of the regulatory reforms. Net income includes amortization of deferred reinsurance gain—LPT Agreement of $14.6 million and $15.5 million in the nine months ended September 30, 2006 and 2005, respectively. Excluding this item, net income would have been $101.9 million and $47.6 million in the nine months ended September 30, 2006 and 2005, respectively. Net income for the nine months ended September 30, 2005 and 2006 did not include any adjustment to LPT Agreement ceded reserves, as our reevaluation of the direct reserves subject to the LPT Agreement did not result in an adjustment for the nine months ended September 30, 2006 and 2005.

Losses and LAE ratio decreased 31.0 percentage points, to 31.9%, for the nine months ended September 30, 2006 from 62.9% for the nine months ended September 30, 2005. As discussed under ‘‘—Losses and LAE’’ above, decrease in the losses and LAE ratio was primarily due to recognition of favorable development for prior accident years recognized through the nine months ended September 30, 2006. The losses and LAE ratio include amortization of deferred reinsurance gain—LPT Agreement of $14.6 million and $15.5 million for the nine months ended September 30,

2006 and 2005, respectively. Excluding this item, the losses and LAE ratio would have been 36.8% and 67.6% in the nine months ended September 30, 2006 and 2005, respectively. The losses and LAE ratio for the nine months ended September 30, 2005 and 2006 did not include any adjustment to LPT Agreement ceded reserves, as our reevaluation of the direct reserves subject to the LPT Agreement did not result in an adjustment for the periods ended September 30, 2006 and 2005.

Commission expense ratio increased 1.1 percentage points, to 12.2%, for the nine months ended September 30, 2006 from 11.1% for nine months ended September 30, 2005. The commission expense ratio increase was primarily due to an increase in the Nevada assigned risk market assessment in combination with the impact of premium rate declines in California, the result of regulatory reforms.

Underwriting and other operating expense ratio increased by 5.3 percentage points, to 19.7%, for the nine months ended September 30, 2006 from 14.4% for the nine months ended September 30, 2005. The underwriting and other operating expense ratio increase was primarily due to an increase in payroll and employee benefits expense, which were incurred to support increased in force policy count.

Combined ratio decreased 24.6 percentage points, to 63.8%, for the nine months ended September 30, 2006 from 88.4% for the nine months ended September 30, 2005. The combined ratio decrease was primarily due to the decreased losses and LAE ratio that was partially offset by increased commission expense and underwriting and other operating expense ratios.



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Year Ended December 31, 2005 Compared to Year Ended December 31, 2004

| | Year Ended December 31, | | Increase (Decrease) 2005 Over 2004 | Increase (Decrease) 2005 Over 2004 |
|---|---|---|---|---|
| | 2004 | 2005 | (in thousands, except percentages and percentage points) | |
| Selected Financial Data: | | | | |
| Gross premiums written | $ 437,694 | $ 458,671 | $ 20,977 | 4.8% |
| Net premiums written | 417,914 | 439,721 | 21,807 | 5.2 |
| Net premiums earned | 410,302 | 438,250 | 27,948 | 6.8 |
| Net investment income | 42,201 | 54,416 | 12,215 | 28.9 |
| Realized gains (losses) on investments | 1,202 | (95) | (1,297) | (107.9) |
| Other income | 2,950 | 3,915 | 965 | 32.7 |
| Total revenue | 456,655 | 496,486 | 39,831 | 8.7 |
| Losses and LAE | 229,219 | 211,688 | (17,531) | (7.6) |
| Commission expense | 55,369 | 46,872 | (8,497) | (15.3) |
| Underwriting and other operating expense | 65,492 | 69,934 | 4,442 | 6.8 |
| Income taxes | 11,008 | 30,394 | 19,386 | 176.1 |
| Net income | $ 95,567 | $ 137,598 | $ 42,031 | 44.0% |
| Selected Operating Data: | | | | |
| Losses and LAE ratio | 55.9% | 48.3% | (7.6) | n/a |

Commission expense ratio