AMERISAFE INC
Form 10-K
February 26, 2016
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE

SECURITIES EXCHANGE ACT OF 1934

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2015

Commission File Number: 001-12251

AMERISAFE, INC.

(Exact Name of Registrant as Specified in Its Charter)

Texas	**75-2069407**
(State of Incorporation)	**(I.R.S. Employer Identification Number)**

2301 Highway 190 West,

DeRidder, Louisiana 70634
(Address of Principal Executive Offices) (Zip Code)
Registrant s telephone number, including area code: (337) 463-9052

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.01 per share	Nasdaq Stock Market LLC

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

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

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

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

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes x No ¨

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer x	Accelerated filer ¨
Non-accelerated filer ¨ (Do not check if a smaller reporting company)	Smaller reporting company ¨

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No x

The aggregate market value of the voting common stock held by non-affiliates of the Registrant as of June 30, 2015 (the last business day of the Registrant s most recently completed second fiscal quarter) was approximately $880.7 million, based upon the closing price of the shares on the NASDAQ Global Select Market on that date.

As of February 15, 2016, there were 19,130,522 shares of the Registrant s common stock, par value $0.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s Proxy Statement relating to the 2016 Annual Meeting of Shareholders are incorporated by reference in Items 10, 11, 12, 13 and 14 of Part III of this report.

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FORWARD-LOOKING STATEMENTS

This report contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and 21E of the Securities Exchange Act of 1934. You should not place undue reliance on these statements. These forward-looking statements include statements that reflect the current views of our senior management with respect to our financial performance and future events with respect to our business and the insurance industry in general. Statements that include the words expect, intend, plan, believe, project, forecast, estimate, may, shoul similar statements of a future or forward-looking nature identify forward-looking statements. Forward-looking statements address matters that involve risks and uncertainties. Accordingly, there are or will be important factors that could cause our actual results to differ materially from those indicated in these statements. We believe that these factors include, but are not limited to, the following:

- the cyclical nature of the workers compensation insurance industry;
- general economic conditions, including recession, inflation, performance of financial markets, interest rates, unemployment rates and fluctuating asset values;
- decreased demand for our insurance;
- increased competition on the basis of types of insurance offered, premium rates, coverage availability, payment terms, claims management, safety services, policy terms, overall financial strength, financial ratings and reputation;
- greater frequency or severity of claims and loss activity, including as a result of natural or man-made catastrophic events, than our underwriting, reserving or investment practices anticipate based on historical experience or industry data;
- technology breaches or failures, including those resulting from a malicious cyber attack on the Company or its policyholders and medical providers;
- adverse developments in economic, competitive, judicial or regulatory conditions within the workers compensation insurance industry;
- changes in regulations, laws, rates, or rating factors applicable to the Company, its policyholders or the agencies that sell its insurance;
- loss of the services of any of our senior management or other key employees;

changes in rating agency policies, practices or ratings;

changes in the availability, cost or quality of reinsurance and the failure of our reinsurers to pay claims in a timely manner or at all;

decreased level of business activity of our policyholders caused by decreased business activity generally, and in particular in the industries we target;

changes in legal theories of liability under our insurance policies;

developments in capital markets that adversely affect the performance of our investments;

the effects of U.S. involvement in hostilities with other countries and large-scale acts of terrorism, or the threat of hostilities or terrorist acts; and

other risks and uncertainties described from time to time in the Company s filings with the Securities and Exchange Commission (SEC).

The foregoing factors should not be construed as exhaustive and should be read together with the other cautionary statements in this report, including under the caption Risk Factors in Item 1A of this report. If one or more events related to these or other risks or uncertainties materialize, or if our underlying assumptions prove to be incorrect, actual results may differ materially from what we anticipate.

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PART I

Item 1. Business.

Overview

We are a specialty provider of workers compensation insurance focused on small to mid-sized employers engaged in hazardous industries, principally construction, trucking, manufacturing, agriculture and oil and gas. Since commencing operations in 1986, we have gained significant experience underwriting the complex workers compensation exposures inherent in these industries. We provide coverage to employers under state and federal workers compensation laws. These laws prescribe wage replacement and medical care benefits that employers are obligated to provide to their employees who are injured in the course and scope of their employment. Our workers compensation insurance policies provide benefits to injured employees for, among other things, temporary or permanent disability, death and medical and hospital expenses. The benefits payable and the duration of those benefits are set by state or federal law. The benefits vary by jurisdiction, the nature and severity of the injury and the wages of the employee. The employer, who is the policyholder, pays the premiums for coverage.

Hazardous industry employers tend to have less frequent but more severe claims as compared to employers in other industries due to the nature of their businesses. Injuries that occur are often severe in nature including death, dismemberment, paraplegia and quadriplegia. As a result, employers engaged in hazardous industries pay substantially higher than average rates for workers compensation insurance compared to employers in other industries, as measured per payroll dollar. The higher premium rates are due to the nature of the work performed and the inherent workplace danger of our target policyholders. For example, our construction employers on average paid premium rates equal to $7.63 per $100 of payroll to obtain workers compensation coverage for all of their employees in 2015.

We employ a proactive, disciplined approach to underwriting employers and providing comprehensive services intended to lessen the overall incidence and cost of workplace injuries. We provide safety services at employers workplaces as a vital component of our underwriting process and to promote safer workplaces. We utilize intensive claims management practices that we believe permit us to reduce the overall cost of our claims. In addition, our premium audit services ensure that our policyholders pay the appropriate premiums required under the terms of their policies and enable us to monitor payroll patterns that cause underwriting, safety or fraud concerns.

We believe that the higher premiums typically paid by our policyholders, together with our disciplined underwriting and safety, claims and audit services, provide us with the opportunity to earn attractive returns on equity.

AMERISAFE, Inc. is an insurance holding company, incorporated in Texas in 1985. We began operations in 1986 by focusing on workers compensation insurance for logging contractors in the southeast United States. Beginning in 1994, we expanded our focus to include the other hazardous industries we serve today. Two of our three insurance subsidiaries, American Interstate Insurance Company and Silver Oak Casualty, are domesticated in Nebraska. Our other insurance subsidiary, American Interstate Insurance Company of Texas, is domiciled in Texas. All three insurance subsidiaries carry an A.M. Best rating of A (Excellent).

Competitive Advantages

We believe we have the following competitive advantages:

Focus on Hazardous Industries. We have extensive experience insuring employers engaged in hazardous industries and have a history of profitably underwriting these industries. Our specialized knowledge of these hazardous industries helps us better serve our policyholders, which leads to greater employer loyalty and policy retention. Our policy renewal rate on voluntary business that we elected to quote for renewal was 92.3% in 2015.

Focus on Small to Mid-Sized Employers. We believe large insurance companies generally do not target small to mid-sized employers in hazardous industries due to their smaller premium sizes, types of operations,

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mobile workforces and extensive service needs. We provide these employers enhanced services, including premium payment plans to better match premium payments with our policyholders payroll costs and cash flow.

Specialized Underwriting Expertise. Based on our 30-year history of insuring employers engaged in hazardous industries, we have developed industry specific risk analysis and rating tools that support our underwriters in risk selection and pricing. We are highly disciplined when quoting and binding new and renewal business. We do not delegate underwriting authority to agencies, marketers or to any other third parties that sell our insurance.

Comprehensive Safety Services. We provide proactive safety reviews of employers worksites, which are often located in rural areas. These safety reviews are a vital component of our underwriting process and also assist our policyholders in loss prevention, and encourage safer workplaces by deploying experienced field safety professionals, or FSPs, to our policyholders worksites. In 2015, 89.5% of our new voluntary business policyholders were subject to pre-quotation safety inspections. Additionally, we perform periodic on-site safety surveys of all of our voluntary business policyholders.

Proactive Claims Management. Our employees manage substantially all of our open claims in-house, utilizing intensive claims management practices that emphasize a personalized approach, as well as quality, cost-effective medical treatment. As of December 31, 2015, open indemnity claims per field case manager, or FCM, averaged 50 claims, which we believe is significantly less than the industry average. We also believe our claims management practices allow us to achieve a more favorable claim outcome, accelerate an employee s return to work, lessen the likelihood of litigation and more rapidly close claims, all of which ultimately lead to lower overall claim costs.

Efficient Operating Platform. Through extensive cost management initiatives, we maintain one of the most efficient operations in the workers compensation industry. In 2015, our expense ratio was 22.4%. We believe that our expense ratio is substantially lower than that of our competitors, which gives us a greater opportunity to generate an underwriting profit.

Strategy

We intend to produce favorable returns on equity and increase our book value per share adjusted for dividends paid to shareholders using the following strategies:

Focus on Underwriting Profitability. We intend to maintain our underwriting discipline throughout market cycles with the objective of remaining profitable. Our strategy is to focus on underwriting workers compensation insurance in hazardous industries and to maintain adequate rate levels commensurate with the risks we underwrite. We will also continue to strive for improved risk selection and pricing, as well as reduced frequency and severity of claims through comprehensive workplace safety reviews, effective medical cost containment measures and rapid closing of claims through personal, direct contact with our policyholders and their employees.

Increase Market Penetration. Based on data received from the National Association of Insurance Commissioners, the NAIC, we do not have more than 5.5% of the market share in any state we serve. As a result, we believe we have the opportunity to increase market penetration in each of the states in which we currently operate. Competition in our target markets is fragmented by state, employer size and industry. We believe that our specialized underwriting expertise and safety, claims and audit services position us to profitably increase our market share in our existing principal markets, with minimal increase in field service employees.

Prudent and Opportunistic Geographic Expansion. While we actively market our insurance in 27 states, 50.4% of our voluntary in-force premiums were generated in the six states where we derived 5.0% or more of our gross premiums

written in 2015. We are licensed in an additional 20 states, the District of Columbia and the U.S. Virgin Islands. Our existing licenses and rate filings will expedite our ability to write policies in these markets when we decide it is prudent to do so.

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Capitalize on Development of Information Technology Systems. We believe our underwriting and agency management system, *GEAUX*, along with our customized operational system, *ICAMS*, and the analytical data warehouse that ICAMS feeds, significantly enhance our ability to select risk, write profitable business and cost-effectively administer our billing, claims and audit functions.

Maintain Capital Strength. We plan to manage our capital to achieve our profitability goals while striving for optimal operating leverage for our insurance company subsidiaries. To accomplish this objective, we intend to maintain underwriting profitability throughout market cycles, optimize our use of reinsurance, deploy appropriate capital management tools including paying dividends to shareholders and produce an appropriate risk adjusted return on our investment portfolio.

Industry

Overview. Workers compensation is a statutory system under which an employer is required to pay for its employees medical, disability, vocational rehabilitation and death benefit costs for work-related injuries or illnesses. Most employers satisfy this requirement by purchasing workers compensation insurance. The principal concept underlying workers compensation laws is that employees injured in the course and scope of their employment have only the legal remedies available under workers compensation laws and do not have any other recourse against their employer. An employer s obligation to pay workers compensation does not depend on any negligence or wrongdoing on the part of the employer and exists even for injuries that result from the negligence or fault of another person, a co-employee, or, in most instances, the injured employee.

Workers compensation insurance policies generally provide that the insurance carrier will pay all benefits that the insured employer may become obligated to pay under applicable workers compensation laws. Each state has a regulatory and adjudicatory system that quantifies the level of wage replacement to be paid, determines the level of medical care required to be provided and the cost of temporary or permanent impairment and specifies the options in selecting medical providers available to the injured employee or the employer. These state laws generally require two types of benefits for injured employees: (1) medical benefits, which include expenses related to the diagnosis and treatment of the injury, as well as any required rehabilitation, and (2) indemnity payments, which consist of temporary wage replacement, permanent disability payments and death benefits to surviving family members. To fulfill these mandated financial obligations, virtually all employers are required to purchase workers compensation insurance or, if permitted by state law or approved by the U.S. Department of Labor, to self-insure. The employers may purchase workers compensation insurance from a private insurance carrier, a state-sanctioned assigned risk pool, or a self-insurance fund, which is an entity that allows employers to obtain workers compensation coverage on a pooled basis, typically subjecting each employer to joint and several liability for the entire fund.

Workers compensation was the fourth-largest property and casualty insurance line in the United States in 2014, according to the National Council on Compensation Insurance, Inc., the NCCI. Direct premiums written in 2014 for the workers compensation insurance industry were $55 billion, and direct premiums written for the property and casualty industry as a whole were $570 billion. According to the most recent market data reported by the NCCI, which is the official rating bureau in the majority of states in which we are licensed, total premiums reported for the specific occupational class codes for which we underwrite business were $15.2 billion.

Policyholders

As of December 31, 2015, we had more than 8,000 voluntary business policyholders with an average annual workers compensation policy written premium of $42,366. As of December 31, 2015, our ten largest voluntary business policyholders accounted for 2.6% of our in-force premiums. Our policy renewal rate on voluntary business that we

elected to quote for renewal was 92.3% in 2015, 91.3% in 2014, and 92.3% in 2013.

In addition to our voluntary workers compensation business, we underwrite workers compensation policies for employers assigned to us and assume reinsurance premiums from mandatory pooling arrangements, in each case to fulfill our obligations under residual market programs implemented by the states in which we

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operate. Our assigned risk business fulfills our statutory obligation to participate in residual market plans in four states. See Regulation Residual Market Programs below. For the year ended December 31, 2015, our assigned risk business accounted for 1.2% of our gross premiums written, and our assumed premiums from mandatory pooling arrangements accounted for 2.4% of our gross premiums written.

Targeted Industries

We provide workers compensation insurance primarily to employers in the following targeted hazardous industries:

Construction. Includes a broad range of operations such as highway and bridge construction, building and maintenance of pipeline and powerline networks, excavation, commercial construction, roofing, iron and steel erection, tower erection and numerous other specialized construction operations. In 2015, our average policy premium for voluntary workers compensation within the construction industry was $43,040, or $7.63 per $100 of payroll.

Trucking. Includes a broad spectrum of diverse operations including contract haulers, regional and local freight carriers, special equipment transporters and other trucking companies that conduct a variety of short- and long-haul operations. In 2015, our average policy premium for voluntary workers compensation within the trucking industry was $43,946, or $9.52 per $100 of payroll.

Manufacturing. Includes a diverse group of policyholders businesses such as the production of goods for use or sale using labor and machines, tools, chemical and biological processing or formulation. In 2015, our average policy premium for voluntary workers compensation within the manufacturing industry was $43,531, or $5.14 per $100 of payroll.

Agriculture. Includes crop maintenance and harvesting, grain and produce operations, nursery operations, meat processing, and livestock feed and transportation. In 2015, our average policy premium for voluntary workers compensation within the agriculture industry was $27,863, or $6.77 per $100 of payroll.

Oil and Gas. Includes various oil and gas activities including gathering, transportation, processing, production, and field service operations. In 2015, our average policy premium for voluntary workers compensation within the oil and gas industry was $43,709, or $5.33 per $100 of payroll.

Logging. Includes tree harvesting operations ranging from labor intensive chainsaw felling and trimming to sophisticated mechanized operations using heavy equipment. In 2015, our average policy premium for voluntary workers compensation within the logging industry was $29,698, or $14.32 per $100 of payroll.

Maritime. Includes ship building and repair, pier and marine construction, inter-coastal construction, and stevedoring. In 2015, our average policy premium for voluntary workers compensation within the maritime industry was $47,894, or $5.03 per $100 of payroll.

Our gross premiums are derived from:

Voluntary Business. Includes direct premiums from workers compensation insurance policies that we issue to employers who seek to purchase insurance directly from us and who we voluntarily agree to insure.

Assigned Risk Business. Includes direct premiums from workers compensation insurance policies that we issue to employers assigned to us under residual market programs implemented by some of the states in which we operate.

Assumed Premiums. Includes premiums from our participation in mandatory pooling arrangements under residual market programs implemented by some of the states in which we operate.

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Gross premiums written during the years ended December 31, 2015, 2014 and 2013, and the allocation of those premiums among the hazardous industries we target are presented in the table below.

	Gross Premiums Written			Percentage of Gross Premiums Written		
	2015	2014	2013	2015	2014	2013
	(in thousands)					
Voluntary business:						
Construction	$ 164,717	$ 166,360	$ 153,110	42.6%	42.2%	41.2%
Trucking	71,872	69,520	71,565	18.6%	17.7%	19.2%
Manufacturing	31,778	28,239	27,122	8.2%	7.2%	7.3%
Agriculture	16,133	15,426	15,563	4.2%	3.9%	4.2%
Oil and Gas	10,128	15,802	17,976	2.6%	4.0%	4.8%
Logging	8,748	7,200	8,132	2.3%	1.8%	2.2%
Maritime	7,839	11,413	10,883	2.0%	2.9%	2.9%
Other	61,352	65,475	55,554	15.9%	16.6%	14.9%
Total voluntary business	372,567	379,435	359,905	96.4%	96.3%	96.7%
Assigned risk business	4,515	5,198	4,342	1.2%	1.3%	1.2%
Assumed premiums	9,447	9,186	7,930	2.4%	2.4%	2.1%
Total	$ 386,529	$ 393,819	$ 372,177	100.0%	100.0%	100.0%

Geographic Distribution

We are licensed to provide workers compensation insurance in 47 states, the District of Columbia and the U.S. Virgin Islands. We operate on a geographically diverse basis with 10.7% or less of our gross premiums written in 2015 derived from any one state. The table below identifies, for the years ended December 31, 2015, 2014 and 2013, the states in which the percentage of our gross premiums written exceeded 3.0% for any of the three years presented.

	Percentage of Gross Premiums Written Year Ended December 31,		
State	2015	2014	2013
Georgia	10.7%	10.2%	9.2%
Louisiana	10.1%	12.0%	12.6%
Pennsylvania	9.8%	9.3%	9.2%
Florida	6.8%	6.2%	4.5%
Illinois	6.6%	5.6%	5.6%
North Carolina	5.3%	5.4%	6.1%
Virginia	4.1%	4.3%	4.6%
Minnesota	4.0%	3.8%	3.3%
Texas	3.8%	4.0%	4.4%
South Carolina	3.6%	3.2%	3.4%

Oklahoma	3.5%	4.1%	4.8%
Wisconsin	3.4%	2.5%	2.4%
Mississippi	2.9%	3.0%	2.7%
Alaska	2.9%	3.1%	3.7%
Tennessee	2.2%	2.3%	3.2%
Total	79.7%	79.0%	79.7%

Sales and Marketing

We sell our workers compensation insurance through agencies. As of December 31, 2015, our insurance was sold through more than 3,000 independent agencies and our wholly-owned insurance agency subsidiary,

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Amerisafe General Agency, which is licensed in 28 states. We are selective in establishing and maintaining relationships with independent agencies. We seek to do business with those agencies that provide quality application flow from companies operating in our target industries and classes that are reasonably likely to accept our quotes. We compensate these agencies by paying a commission based on the premium collected from the policyholder. Our average commission rate for our independent agencies was 7.5% for the year ended December 31, 2015. We pay our insurance agency subsidiary a commission rate of 8.2%. Neither our independent agencies nor our insurance agency subsidiary has authority to underwrite or bind coverage. We do not pay contingent commissions.

As of December 31, 2015, independent agencies accounted for 97.0% of our voluntary in-force premiums. No single independent agency accounted for more than 1.3% of our voluntary in-force premiums at that date.

Underwriting

Our underwriting strategy is to focus on employers in certain hazardous industries that operate in those states where our underwriting efforts are the most profitable and efficient. We analyze each prospective policyholder on its own merits relative to known industry trends and statistical data. Our underwriting guidelines specify that we do not write workers compensation insurance for certain hazardous activities, including sub-surface mining and manufacturing of ammunition or fireworks.

Underwriting is a multi-step process that begins with the receipt of an application from one of our agencies. We initially review the application to confirm that the prospective policyholder meets certain established criteria, including that the prospective policy holder is engaged in one of our targeted hazardous industries and industry classes and operates in the states we target. If the application satisfies these criteria, the application is forwarded to our underwriting department for further review.

Our underwriting department reviews the application to determine if the application meets our underwriting criteria and whether all required information has been provided. If additional information is required, the underwriting department requests additional information from the agency submitting the application. This initial review process is generally completed within three days after the application is received by us**.** Once this initial review process is complete, our underwriting department requests that a pre-quotation safety inspection be performed in most cases. In 2015, 89.5% of our new voluntary business policyholders were inspected prior to our offering a premium quote.

After the pre-quotation safety inspection has been completed, our underwriting professionals review the results of the inspection to determine if a quote should be made and, if so, prepare the quote. The quote must be reviewed and approved by our underwriting department before the quote is delivered to the agency. All decisions by our underwriting department, including decisions to decline applications, are subject to review and approval by our management-level underwriters.

Our underwriting professionals participate in an incentive compensation program under which bonuses are paid quarterly based upon achieving premium underwriting volume and loss ratio targets. The determination of whether targets have been satisfied is made 30 months after the beginning of the relevant incentive compensation period.

Pricing

In the majority of states, workers compensation insurance rates are based upon published loss costs. Loss costs are derived from wage and loss data reported by insurers to the state s statistical agent, which in most states is the NCCI. The state agent then promulgates loss costs for specific job descriptions or class codes. Insurers file requests for adoption of a loss cost multiplier, or LCM, to be applied to the loss costs to support operating expenses and profit

margins. In addition, most states allow pricing flexibility above and below the filed LCM, within certain limits.

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We obtain approval of our rates, including our LCMs, from state regulatory authorities. To maintain rates at profitable levels, we regularly monitor and adjust our LCMs. The effective LCM for our voluntary business was 1.79 for policy year 2015, 1.84 for policy year 2014, and 1.79 for policy year 2013. If we are unable to charge rates in a particular state or industry to produce satisfactory results, we seek to control and reduce our premium volume in that state or industry and redeploy our capital in other states or industries that offer greater opportunity to earn an underwriting profit.

Safety

Our safety inspection process begins with a request from our underwriting department to perform a pre-quotation safety inspection. Our safety inspections focus on a prospective policyholder s operations, loss exposures and existing safety controls to prevent potential losses. The factors considered in our inspection include employee experience, turnover, training, previous loss history and corrective actions, and workplace conditions, including equipment condition and, where appropriate, use of fall protection, respiratory protection or other safety devices. Our FSPs travel to employers worksites to perform these safety inspections. These initial inspections allow our underwriting professionals to make decisions on both insurability and pricing. In certain circumstances, we will agree to provide workers compensation insurance only if the employer agrees to implement and maintain the safety management practices that we recommend. In 2015, 89.5% of our new voluntary business policyholders were inspected prior to our offering a premium quote. The remaining voluntary business policies were not pre-quote inspected for a variety of reasons, including instances where the prospective policyholder was previously insured by us or previously inspected by us.

After an employer becomes a policyholder, we continue to emphasize workplace safety through periodic workplace visits, assisting the policyholder in designing and implementing enhanced safety management programs, providing safety-related information and conducting rigorous post-accident management. Generally, we may cancel or decline to renew an insurance policy if the policyholder does not implement or maintain reasonable safety management practices that we recommend.

Our FSPs participate in an incentive compensation program under which bonuses are paid semi-annually based upon an FSP s production and their policyholders aggregate loss ratios. The results are measured 33 months after the inception of the subject policy period.

Claims

We have structured our claims operation to provide immediate, intensive and personal management of claims to guide injured employees through medical treatment, rehabilitation and recovery, with the primary goal of returning the injured employee to work as promptly as practicable and at maximum medical improvement. We seek to limit the number of claim disputes with injured employees through early intervention in the claims process. Where possible, we purchase annuities on longer life claims to close such claims, while still providing an appropriate level of benefits to injured employees. While we seek to promptly settle valid claims, we also aggressively defend against claims we consider to be non-meritorious.

Our FCMs are located in the geographic areas where our policyholders are based. We believe the presence of our FCMs in the field enhances our ability to guide an injured employee to the appropriate conclusion in a friendly, dignified and supportive manner. Our FCMs have broad authority to manage claims from occurrence of a workplace injury through resolution, including authority to retain many different medical providers at our expense. Such providers comprise not only our recommended medical providers, but also nurse case managers, independent medical examiners, vocational specialists, rehabilitation specialists and other specialty providers of medical services necessary

to achieve a quality outcome.

Following notification of a workplace injury, an FCM will contact the policyholder, the injured employee and/or the treating physician to determine the nature and severity of the injury. If a serious injury occurs, the FCM will promptly visit the injured employee or the employee s family members to discuss the benefits provided. The FCM will also visit the treating physician to discuss the proposed treatment plan. Our FCM assists the injured employee in receiving appropriate medical treatment and encourages the use of our recommended

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medical providers and facilities. For example, our FCM may suggest that a treating physician refer an injured worker to another physician or treatment facility that we believe has had positive outcomes for other workers with similar injuries. We actively monitor the number of open cases handled by a single FCM in order to maintain focus on each specific injured employee. As of December 31, 2015, we averaged 50 open indemnity claims per FCM, which we believe is significantly less than the industry average.

Locating our FCMs in the field also allows us to build professional relationships with local medical providers. In selecting medical providers, we rely, in part, on the recommendations of our FCMs who have developed professional relationships within their geographic areas. We also seek input from our policyholders and other contacts in the markets that we serve. While cost factors are considered in selecting medical providers, we consider the most important factor in the selection process to be the medical provider s ability to achieve a quality outcome. We define quality outcome as the injured worker s rapid, conclusive recovery and return to sustained, full capacity employment.

Premium Audits

We conduct premium audits on all of our voluntary business policyholders annually upon the expiration of each policy, including when the policy is renewed. The purpose of these audits is to verify that policyholders have accurately reported their payroll expenses and employee job classifications, and therefore, have paid us the premium required under the terms of their policies. In addition to annual audits, we selectively perform interim audits on certain classes of business if significant or unusual claims are filed or if the monthly reports submitted by a policyholder reflect a payroll pattern or other aberrations that cause underwriting, safety or fraud concerns. We also mitigate potential losses from under-reporting of premium or delinquent premium payment by collecting a deposit from the policyholder at the inception of the policy, typically representing 15% of the total estimated annual premium, which deposit can be utilized to offset losses from non-payment of premium.

Loss Reserves

We record reserves for estimated losses under insurance policies that we write and for loss adjustment expenses related to the investigation and settlement of policy claims. Our reserves for loss and loss adjustment expenses represent the estimated cost of all reported and unreported loss and loss adjustment expenses incurred and unpaid as of a given point in time.

In establishing our reserves, we review the results of analyses using actuarial methodologies that utilize historical loss data from our more than 30 years of underwriting workers compensation insurance. In evaluating the results of those analyses, our management also uses substantial judgment in considering other factors that are not considered in these actuarial analyses. These actuarial methodologies and subjective factors are described in more detail below. Our process and methodology for estimating reserves applies to both our voluntary and assigned risk business, but does not include our reserves for mandatory pooling arrangements. We record reserves for mandatory pooling arrangements as those reserves are reported to us by the pool administrators. We do not use loss discounting when we determine our reserves, which would involve recognizing the time value of money and offsetting estimates of future payments by future expected investment income.

When a claim is reported, we establish an initial case reserve for the estimated amount of our loss based on our estimate of the most likely outcome of the claim at that time. Generally, that case reserve is established within 14 days after the claim is reported and consists of anticipated medical costs, indemnity costs and specific adjustment expenses, which we refer to as defense and cost containment expenses, or DCC expenses. The most complex claims, involving severe injuries, may take a considerable period of time for us to establish a more precise estimate of the most likely outcome of the claim. At any point in time, the amount paid on a claim, plus the reserve for future amounts to be paid,

represents the estimated total cost of the claim, or the case incurred amount. The estimated amount of loss for a reported claim is based upon various factors, including:

type of loss;

severity of the injury or damage;

age and occupation of the injured employee;

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estimated length of temporary disability;

anticipated permanent disability;

expected medical procedures, costs and duration;

our knowledge of the circumstances surrounding the claim;

insurance policy provisions related to the claim, including coverage;

jurisdiction of the occurrence; and

other benefits defined by applicable statute.

The case incurred amount varies over time due to uncertainties with respect to medical treatment and outcome, length and degree of disability, recurrence of injury, employment availability and wage levels and judicial determinations. As changes occur, the case incurred amount is adjusted. The initial estimate of the case incurred amount can vary significantly from the amount ultimately paid, especially in circumstances involving severe injuries with comprehensive medical treatment. Changes in case incurred amounts is an important component of our historical claim data.

In addition to case reserves, we establish reserves on an aggregate basis for loss and DCC expenses that have been incurred but not reported, or IBNR. Our IBNR reserves are also intended to provide for aggregate changes in case incurred amounts as well as the unpaid cost of recently reported claims for which an initial case reserve has not been established.

The third component of our reserves for loss and loss adjustment expenses is our adjusting and other reserve, or AO reserve. Our AO reserve covers primarily the estimated cost of administering claims and is established for the costs of future unallocated loss adjustment expenses for all reported and unreported claims.

The final component of our reserves for loss and loss adjustment expenses is the reserve for mandatory pooling arrangements. The mandatory pooling arrangement reserve includes the amount reported to us by the pool administrators.

In establishing reserves, we rely on the analysis of the more than 199,000 claims in our 30-year history. Using statistical analyses and actuarial methods, we estimate reserves based on historical patterns of case development, payment patterns, mix of business, premium rates charged, case reserving adequacy, operational changes, adjustment philosophy and severity and duration trends.

We review our reserves by accident year and state on a quarterly basis. Individual open claims are reviewed more frequently and adjustments to case incurred amounts are made based on expected outcomes. The number of claims reported or occurring during a period, combined with a calculation of average case incurred amounts, and measured over time, provide the foundation for our reserve estimates. In establishing our reserve estimates, we use historical

trends in claim reporting timeliness, frequency of claims in relation to earned premium or covered payroll, premium rate levels charged and case development patterns. However, the number of variables and judgments involved in establishing reserve estimates, combined with some random variation in loss development patterns, results in uncertainty regarding projected ultimate losses. As a result, our ultimate liability for loss and loss adjustment expenses may be more or less than our reserve estimate.

Our analysis of our historical data provides the factors we use in our statistical and actuarial analysis in estimating our loss and DCC expense reserve. These factors are primarily measures over time of claims reported, average case incurred amounts, case development, duration, severity and payment patterns. However, these factors cannot be solely used as these factors do not take into consideration changes in business mix, claims management, regulatory issues, medical trends, medical inflation, employment and wage patterns, and other subjective factors. We use this combination of factors and subjective assumptions in the use of six well-accepted actuarial methods, as follows:

Paid Development Method uses historical, cumulative paid loss patterns to derive estimated ultimate losses by accident year based upon the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years.

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Paid Weighted Severity Method multiplies estimated ultimate claims for each accident year by a weighted average, trended and developed severity. The ultimate claims estimate is based on paid claim count development. The selected severity for a given accident year is derived by giving some weight to all of the accident years in the experience history rather than treating each accident year independently.

Paid Loss Ratio Cape Cod Method similar to the paid weighted severity method, except that on-level premiums replace estimated ultimate claims, based upon paid claim count development, and loss ratios replace selected severities. The selected ultimate loss ratio for a given accident year is derived by giving some weight to all of the accident years in the experience history rather than treating each accident year independently.

Incurred Development Method uses historical, cumulative incurred loss patterns to derive estimated ultimate losses by accident year based upon the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years.

Incurred Weighted Severity Method multiplies estimated ultimate claims for each accident year by a weighted average, trended and developed severity. The ultimate claims estimate is based on incurred claim count development. The selected severity for a given accident year is derived by giving some weight to all of the accident years in the experience history rather than treating each accident year independently.

Incurred Loss Ratio Cape Cod Method similar to the incurred weighted severity method, except that on-level premiums replace estimated ultimate claims, based upon incurred claim count development, and loss ratios replace selected severities. The selected ultimate loss ratio for a given accident year is derived by giving some weight to all of the accident years in the experience history rather than treating each accident year independently.

These six methods are applied to both gross and net claims data. We then analyze the results and may emphasize or de-emphasize some or all of the outcomes to reflect our judgment of reasonableness in relation to supplementary information and operational and industry changes. These outcomes are then aggregated to produce a single weighted average point estimate that is the base estimate for loss and DCC expense reserves.

In determining the level of emphasis that may be placed on some or all of the methods, we review statistical information as to which methods are most appropriate, whether adjustments are appropriate within the particular methods, and if results produced by each method include inherent bias reflecting operational and industry changes. This supplementary information may include:

open and closed claim counts;

statistics related to open and closed claim count percentages;

claim closure rates;

changes in average case reserves and average loss and DCC expenses incurred on open claims;

reported and ultimate average case incurred changes;

reported and projected ultimate loss ratios; and

loss payment patterns.

In establishing our AO reserves, we review our past adjustment expenses in relation to paid claims as well as estimated future costs based on expected claims activity and duration.

The sum of our net loss and DCC expense reserve, our AO reserve and our reserve for mandatory pooling arrangements is our total net reserve for loss and loss adjustment expenses.

As of December 31, 2015, our best estimate of our ultimate liability for loss and loss adjustment expenses, net of amounts recoverable from reinsurers, was $653.2 million, which includes $15.8 million in reserves for mandatory pooling arrangements as reported by the pool administrators. The estimate of our ultimate liability

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was derived from the process and methodology described above, which relies on substantial judgment. There is inherent uncertainty in estimating our reserves for loss and loss adjustment expenses. It is possible that our actual loss and loss adjustment expenses incurred may vary significantly from our estimates. We view our estimate of loss and DCC expenses as the most significant component of our reserve for loss and loss adjustment expenses.

Additional information regarding our reserve for unpaid loss and loss adjustment expenses (LAE) as of December 31, 2015, 2014, and 2013 is set forth below:

	2015	2014	2013
		(in thousands)	
Gross case loss and DCC reserves	$ 537,883	$ 514,874	$ 473,019
AO reserves	20,734	18,572	17,187
Gross IBNR reserves	159,416	154,156	124,351
Gross unpaid loss, DCC and AO reserves	718,033	687,602	614,557
Reinsurance recoverables on unpaid loss and LAE	(64,858)	(59,334)	(48,699)
Net unpaid loss, DCC and AO reserves	$ 653,175	$ 628,268	$ 565,858

We performed sensitivity analyses to show how our net loss and DCC expense reserve, including IBNR, would be impacted by changes in certain critical assumptions. For our paid and incurred development methods, we varied both the cumulative paid and incurred loss development factors (LDFs) by plus and minus 30%, both individually and in combination with one another. The results of this sensitivity analysis, using December 31, 2015 data, are summarized below.

Change in Paid LDFs	Change in Incurred LDFs	Resultant Change in Net Loss and DCC Reserve	
		Amount ($) (in thousands)	Percentage
+30%	+30%	43,072	7.0%
+30%	0%	8,209	1.3%
+30%	30%	(27,550)	(4.5%)
0%	+30%	36,822	6.0%
0%	30%	(37,148)	(6.0%)
30%	+30%	36,307	5.9%
30%	0%	(5,525)	(0.9%)
30%	30%	(46,332)	(7.5%)

For our paid and incurred weighted severity methods, we varied our year-end selected trend factor (for medical costs, defense costs, wage inflation, etc.) by plus and minus 50%. The results of this sensitivity analysis, using December 31, 2015 data, are summarized below.

Change in Severity Trend	Resultant Change in Net Loss and DCC Reserve Amount ($) (in thousands)	Percentage
+50%	6,518	1.1%
50%	(5,405)	(0.9%)

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Reconciliation of Loss Reserves

The table below shows the reconciliation of loss reserves on a gross and net basis for the years ended December 31, 2015, 2014 and 2013, reflecting changes in losses incurred and paid losses.

	Year Ended December 31,		
	2015	2014	2013
	(in thousands)		
Balance, beginning of period	$ 687,602	$ 614,557	$ 570,450
Less amounts recoverable from reinsurers on unpaid loss and loss adjustment expenses	59,334	48,699	55,190
Net balance, beginning of period	628,268	565,858	515,260
Add incurred related to:			
Current accident year	262,387	268,633	241,584
Prior accident years	(47,814)	(23,717)	(12,611)
Total incurred	214,573	244,916	228,973
Less paid related to:			
Current accident year	53,955	52 ,848	51,169
Prior accident years	135,711	129,658	127,206
Total paid	189,666	182,506	178,375
Net balance, end of period	653,175	628,268	565,858
Add amounts recoverable from reinsurers on unpaid loss and loss adjustment expenses	64,858	59,334	48,699
Balance, end of period	$ 718,033	$ 687,602	$ 614,557

Our gross reserves for loss and loss adjustment expenses of $718.0 million as of December 31, 2015 are expected to cover all unpaid loss and loss adjustment expenses as of that date. As of December 31, 2015, we had 5,298 open claims, with an average of $135,529 in unpaid loss and loss adjustment expenses per open claim. During the year ended December 31, 2015, 5,465 new claims were reported, and 5,678 claims were closed.

In 2015, our gross reserves increased to $718.0 million from $687.6 million at December 31, 2014. The increase in reserves was attributable primarily to the 2015 accident year. In 2015, we also recognized $47.8 million of favorable development for prior accident years. As of December 31, 2014, we had 5,511 open claims, with an average of $124,679 in unpaid loss and loss adjustment expenses per open claim. During the year ended December 31, 2014, 5,785 new claims were reported, and 5,565 claims were closed.

In 2014, our gross reserves increased to $687.6 million from $614.6 million at December 31, 2013. The increase in reserves was attributable to both the 2014 accident year and prior accident years. In 2014, there was also $23.7 million of favorable development for prior accident years. As of December 31, 2013, we had 5,297 open claims, with an average of $116,020 in unpaid loss and loss adjustment expenses per open claim. During the year ended December 31, 2013, 5,620 new claims were reported, and 5,287 claims were closed.

Loss Development

The table below shows the net loss development for business written each year from 2005 through 2015. The table reflects the changes in our loss and loss adjustment expense reserves in subsequent years from the prior loss estimates based on experience as of the end of each succeeding year on a GAAP basis.

The first line of the table shows, for the years indicated, our liability including the incurred but not reported loss and loss adjustment expenses as originally estimated, net of amounts recoverable from reinsurers. For example, as of December 31, 2005, it was estimated that $364.3 million would be sufficient to settle all claims not already settled that had occurred on or prior to December 31, 2005, whether reported or unreported. The next section of the table sets forth the re-estimates in later years of incurred losses, including payments, for the years

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indicated. The next section of the table shows, by year, the cumulative amounts of loss and loss adjustment expense payments, net of amounts recoverable from reinsurers, as of the end of each succeeding year. For example, with respect to the net loss reserves of $364.3 million as of December 31, 2005, by December 31, 2015 (ten years later) $258.9 million had actually been paid in settlement of the claims that relate to liabilities as of December 31, 2005.

The gross cumulative redundancy (deficiency) represents, as of December 31, 2015, the difference between the latest re-estimated liability and the amounts as originally estimated. A redundancy means that the original estimate was higher than the current estimate. A deficiency means that the current estimate is higher than the original estimate.

Analysis of Loss and Loss Adjustment Expense Reserve Development

	Year Ended December 31,									
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
	(in thousands)									
and										
	$ 364,253	$ 412,366	$ 462,478	$ 474,697	$ 474,220	$ 466,668	$ 477,277	$ 515,260	$ 565,858	$ 628,26
	362,026	402,876	442,091	452,812	452,587	460,105	474,787	502,648	542,141	580,45
	361,181	372,520	416,758	427,794	422,697	454,479	462,650	478,931	494,327	
	346,914	359,590	396,492	398,187	411,516	442,700	448,269	439,272		
	339,849	348,596	371,599	387,525	402,003	429,269	427,835			
	335,158	335,252	364,147	381,950	395,479	411,785				
	325,714	331,390	361,720	377,158	383,827					
-	323,695	330,367	358,630	369,985						
	322,620	328,133	350,693							
	320,520	320,963								
	316,213									
	$ 48,040	$ 91,403	$ 111,785	$ 104,712	$ 90,393	$ 54,883	$ 49,442	$ 75,988	$ 71,531	$ 47,81
unt net eries,										
	110,369	105,408	116,631	121,619	117,555	125,884	131,497	127,205	129,658	135,71
	164,354	167,852	182,879	185,334	182,242	199,682	201,814	188,752	198,610	
	201,393	203,502	217,137	222,249	223,726	240,196	237,170	226,907		
	222,867	224,419	239,189	245,012	248,294	262,415	259,823			
	237,699	235,931	251,941	261,323	261,653	277,396				
	245,466	242,761	261,707	270,241	272,903					
-	249,037	247,681	267,745	278,641						
	253,008	251,651	272,610							

	256,192	254,753								
	258,939									
er 31	$ 364,253	$ 412,366	$ 462,478	$ 474,697	$ 474,220	$ 466,668	$ 477,277	$ 515,260	$ 565,858	$ 628,26
	120,232	106,810	74,925	56,596	60,435	65,536	60,937	55,190	48,699	59,33
er 31	$ 484,485	$ 519,176	$ 537,403	$ 531,293	$ 534,655	$ 532,204	$ 538,214	$ 570,450	$ 614,557	$ 687,60
	$ 316,213	$ 320,963	$ 350,693	$ 369,985	$ 383,827	$ 411,785	$ 427,835	$ 439,272	$ 494,327	$ 580,45
	122,663	116,136	85,939	70,903	54,095	51,729	49,289	44,817	47,733	58,03
ed	$ 438,876	$ 437,099	$ 436,632	$ 440,888	$ 437,922	$ 463,514	$ 477,124	$ 484,089	$ 542,060	$ 638,49
e	$ 45,609	$ 82,077	$ 100,771	$ 90,405	$ 96,733	$ 68,690	$ 61,090	$ 86,361	$ 72,497	$ 49,11

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Investments

We derive net investment income from our invested assets. As of December 31, 2015, the carrying value of our investment portfolio, including cash and cash equivalents, was $1.1 billion and the fair value of the portfolio was $1.1 billion.

Our board of directors has established an investment policy governing our investments, which is reviewed at least annually. The principal objectives of our investment portfolio are to preserve capital and surplus and to maintain appropriate liquidity for corporate requirements. Additional objectives are to support our A.M. Best rating and to maximize after-tax income and total return. Our investment policy establishes limitations and guidelines relating to, for example, asset allocation, diversification, credit ratings and duration. We periodically review our investment portfolio with the risk committee of our board of directors for compliance with the policy. Our investment portfolio is managed internally.

We classify the majority of our fixed maturity securities as held-to-maturity. We do not reflect any changes in fair value for these securities in our financial statements, unless such changes are deemed to be other than temporary impairments, in which case such impairments flow through our income statement within the category, Net realized gains (losses) on investments. The remainder of our fixed maturity securities and all of our equity securities are classified as available-for-sale. These investments are valued at fair value at the end of each period, with changes in fair value flowing through other comprehensive income. We generally seek to limit our holdings in equity securities to the lesser of 10% of the investment portfolio or 30% of shareholders equity, on a fair value basis.

See Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations Investments for further information on the composition and results of our investment portfolio.

The table below shows the carrying values of various categories of securities held in our investment portfolio, the percentage of the total carrying value of our investment portfolio represented by each category and the effective interest rate for the year ended December 31, 2015 based on the carrying value of each category as of December 31, 2015:

	Carrying Value (in thousands)	Percentage of Portfolio	Effective Interest Rate
Fixed maturity securities held-to-maturity:			
State and political subdivisions	$ 408,447	36.6%	3.1%
Corporate bonds	171,224	15.4%	1.7%
Commercial mortgage-backed securities	37,494	3.4%	4.7%
U.S. agency-based mortgage-backed securities	13,223	1.2%	5.0%
U.S. Treasury securities and obligations of U.S. Government agencies	12,487	1.1%	3.1%
Asset-backed securities	2,289	0.2%	3.8%
Total fixed maturity securities held-to-maturity	645,164	57.9%	2.9%
Fixed maturity securities available-for-sale:			

State and political subdivisions		171,419	15.4%	3.3%
Corporate bonds		201,304	18.0%	1.9%
U.S. agency-based mortgage-backed securities		7,299	0.7%	2.8%
Total fixed maturity securities available-for-sale		380,022	34.1%	2.6%
Equity securities		31	0.0%	0.0%
Other investments		12,217	1.1%	0.0%
Cash and cash equivalents		69,481	6.2%	0.1%
Short-term investments		7,718	0.7%	1.1%
Total investments, including cash and cash equivalents	$	1,114,633	100.0%	2.6%

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As of December 31, 2015, our fixed maturity securities had a carrying value of $1,025.2 million, which represented 92.0% of the carrying value of our investments, including cash and cash equivalents. For the twelve months ended December 31, 2015, the pre-tax accounting investment yield of our investment portfolio was 2.5% per annum.

The gross unrealized gains and losses on, and the cost or amortized cost and fair value of, our investment portfolio as of December 31, 2015 are summarized as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in thousands)		
Fixed maturity securities, held-to-maturity	$ 645,164	$ 18,063	$ (951)	$ 662,276
Fixed maturity securities, available-for-sale	376,109	7,199	(3,286)	380,022
Equity securities, available-for-sale		31		31
Other investments, available-for-sale	10,000	2,217		12,217
Totals	$ 1,031,273	$ 27,510	$ (4,237)	$ 1,054,546

As of December 31, 2015, municipal bonds made up 52.0% of our investment portfolio, including cash and short-term investments. The largest concentration results from companies being allowed an investment credit against Louisiana premium taxes for varying levels of Louisiana assets. The table below summarizes the top five geographic exposures as of December 31, 2015.

	Carrying Value (in thousands)	Percentage of Municipal Portfolio	Percentage of Total Portfolio
Louisiana	$ 118,974	20.5%	10.7%
Texas	109,577	18.9%	9.8%
Washington	46,246	8.0%	4.1%
Florida	39,735	6.9%	3.6%
Illinois	21,694	3.7%	1.9%
Other	243,640	42.0%	21.9%
	$ 579,866	100.0%	52.0%

The table below summarizes the credit quality of our investment portfolio, excluding our equity holdings, as of December 31, 2015, as determined by the middle rating of Moody s, Standard and Poor s, and Fitch.

Credit Rating	Percentage of Total Carrying Value

AAA	32.9%
AA	26.5%
A	21.9%
BBB	18.1%
BB and below	0.4%
Unrated securities	0.2%
Total	100.0%

As of December 31, 2015, the average composite rating of our investment portfolio, excluding our equity holdings, was AA-.

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The table below shows the composition of our fixed maturity securities by remaining time to maturity as of December 31, 2015.

Remaining Time to Maturity	As of December 31, 2015	
	Carrying Value (in thousands)	Percentage
Less than one year	$ 144,911	14.1%
One to five years	505,475	49.3%
Five to ten years	129,486	12.6%
More than ten years	185,009	18.1%
U.S. agency-based mortgage-backed securities	20,522	2.0%
Commercial mortgage-backed securities	37,494	3.7%
Asset-backed securities	2,289	0.2%
Total	$ 1,025,186	100.0%

Reinsurance

We purchase reinsurance to reduce our net liability on individual risks and claims and to protect against catastrophic losses. Reinsurance involves an insurance company transferring to, or ceding, a portion of the exposure on a risk to a reinsurer. The reinsurer assumes the exposure in return for a portion of our premium. The cost and limits of reinsurance we purchase can vary from year to year based upon the availability of quality reinsurance at an acceptable price and our desired level of retention. Retention refers to the amount of risk that we retain for our own account. Under excess of loss reinsurance, covered losses in excess of the retention level up to the limit of the program are paid by the reinsurer. Our excess of loss reinsurance is written in layers, in which our reinsurers accept a band of coverage up to a specified amount. Any liability exceeding the limit of the program reverts to us as the ceding company. Reinsurance does not legally discharge us from primary liability for the full amount due under our policies. However, our reinsurers are obligated to indemnify us to the extent of the coverage provided in our reinsurance agreements.

We believe reinsurance is critical to our business. Our reinsurance purchasing strategy is to protect against unforeseen and/or catastrophic loss activity that would adversely impact our income and capital base. We generally select financially strong reinsurers with an A.M. Best rating of A (Excellent) or better at the time we enter into a reinsurance contract. In addition, to minimize our exposure to significant losses from reinsurer insolvencies, we evaluate the financial condition of our reinsurers and monitor concentrations of credit risk on a continual basis.

2016 Excess of Loss Reinsurance Treaty Program

Effective January 1, 2014, we entered into a new multi-year excess of loss reinsurance treaty program related to our voluntary and assigned risk business that applies to losses incurred through December 31, 2016. Our reinsurance treaty program provides us with reinsurance coverage for each loss occurrence up to $70.0 million, subject to applicable limitations, deductibles, retentions and aggregate limits. The maximum loss occurrence involving a single claimant remains limited to a maximum of $10.0 million for that claimant, subject to applicable deductibles, retentions and aggregate limits.

We have 19 reinsurers participating in our reinsurance treaty program in 2016. Under certain circumstances, including a downgrade of a reinsurer s A.M. Best rating to B++ (Very Good) or below, such reinsurer may be required to provide us with security for amounts due under the terms of our reinsurance program. This security may take the form of, among other things, cash advances or letters of credit. If security is required because of a ratings downgrade, the form of security must be mutually agreed to between the reinsurer and us.

In the 2014 program, we raised our retention from $1.0 million to $2.0 million for each loss occurrence when we entered into the new three-year treaty. In 2016, our first layer of reinsurance provides coverage for

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losses up to $10.0 million for each loss occurrence in excess of $2.0 million,. This layer provides coverage in two parts. Before our reinsurers are obligated to reimburse us under this layer, we are subject to an annual aggregate deductible of 1.5% of subject earned premium under the first part of this coverage and 6.5% of subject earned premium under the second part of this coverage. The limit under the first part of this coverage is 5.0% of subject earned premium in any one year and 3.0% of subject earned premium in the aggregate for all three years covered by this layer. The limit under the second part of this coverage is 3.0% of subject earned premium for any one year and 1.5% of subject earned premium in the aggregate for the last two years in this layer.

At our option, we have the right to commute the reinsurers obligations under the agreement at any time after the end of the applicable term of the agreement. If we commute the reinsurers obligations, we are entitled to receive a portion of the premiums that were paid to the reinsurers prior to the effective dates of the applicable commutations, subject to certain adjustments provided in the agreement. This layer of reinsurance will expire on January 1, 2017.

A Catastrophe excess of loss layer affords coverage up to $60.0 million for each loss occurrence in excess of $10.0 million. This layer includes coverage for terrorism including the use and/or dispersal of nuclear, biological, chemical and radiological agents with an annual aggregate limit of $60.0 million. The aggregate limit for all other claims under this layer is $120.0 million. This layer expires on January 1, 2017.

The table below sets forth the reinsurers participating in our 2016 reinsurance program:

Reinsurer	A.M. Best Rating
Hannover Reinsurance (Ireland) Limited	A+
Allianz Risk Transfer AG (Bermuda)	A+
Arch Reinsurance Company	A+
Endurance Reinsurance Corporation of America	A
Markel Global Reinsurance Company	A
Munich Reinsurance America, Inc.	A+
XL Reinsurance America, Inc.	A
Houston Casualty Company	A+
Lloyd s Syndicate 1414 ACS	A
Lloyd s Syndicate 0780 ADV	A
Lloyd s Syndicate 2623 AFB	A
Lloyd s Syndicate 0623 AFB	A
Lloyd s Syndicate 1955 BAR	A
Lloyd s Syndicate 2987 BRT	A
Lloyd s Syndicate 4444 CNP	A
Lloyd s Syndicate 1084 CSL	A
Lloyd s Syndicate 4472 LIB	A
Lloyd s Syndicate 3000 MKL	A
Minnesota Workers Compensation Reinsurance Association	NR

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Due to the nature of reinsurance, we have recoverables from reinsurers that apply to accident years prior to 2015. The table below summarizes our amounts recoverable from reinsurers as of December 31, 2015.

Reinsurer	A.M. Best Rating	Amounts Recoverable as of December 31, 2015 (in thousands)
Hannover Reinsurance (Ireland) Limited (1)	A+	$ 35,530
Odyssey Reinsurance Company	A	12,127
Minnesota Workers Compensation Reinsurance Association (1)	NR	9,034
Tokio Millennium Re Ltd	A++	7,294
Clearwater Insurance Company	bbb	5,610
Finial Reinsurance	A-	4,605
SCOR Reinsurance Company	A	4,213
Allianz Risk Transfer AG (Bermuda) (1)	A+	2,804
St. Paul Fire and Marine Insurance Company	A++	2,038
Clearwater Select Insurance	bbb	1,028
American National Insurance Company	A	958
Lloyd s Syndicate #2000/Harrington	A	856
Other		4,980
Total		$ 91,077

(1) Current participant in our 2016 reinsurance program.

Terrorism Reinsurance

The Terrorism Risk Insurance Act of 2002 (the 2002 Act) was enacted in response to the events of September 11, 2001 and was extended by the Terrorism Risk Insurance Extension Act of 2005 (the 2005 Act), the Terrorism Risk Insurance Program Reauthorization Act of 2007 (the 2007 Act), and the Terrorism Risk Insurance Program Reauthorization Act of 2015 (the 2015 Act). The 2002 Act, the 2005 Act, the 2007 Act and the 2015 Act were designed to ensure the availability of insurance coverage for losses resulting from certain acts of terrorism in the United States. The 2015 Act reauthorized a federal program, established under the 2002 Act, extended by the 2005 Act and 2007 Act, and further extended the program through the end of 2020. This program provides federal reimbursement to insurance companies for a portion of their losses arising from certain acts of terrorism and requires insurance companies to offer coverage for these acts. The program applies to insured losses arising out of acts that are certified as acts of terrorism by the Secretary of the Treasury in concurrence with the Secretary of Homeland Security and the Attorney General of the United States. In addition, the program does not provide any reimbursement for any portion of aggregate industry-wide insured losses from certified acts of terrorism that exceed $100.0 billion in any one year and is subject to certain other limitations and restrictions.

For insured losses in 2016, each insurance group is responsible for a statutory deductible under the 2015 Act that is equal to 20% of its direct earned property and casualty insurance premiums. For losses occurring in 2016, the U.S. Federal Government will reimburse 84% of an insurance group s covered losses over the statutory deductible. The U.S. Federal Government reimbursement will decrease 1% each year until it is 80% in 2020. In addition, no federal

reimbursement is available unless the aggregate insurance industry-wide losses from a certified act of terrorism exceed $120.0 million for any act of terrorism occurring in 2016 and increasing by $20.0 million each year until it is $200.0 million in 2020. However, there is no relief from the requirement under the 2015 Act that insurance companies offer coverage for certified acts of terrorism if those acts do not cause losses exceeding these threshold amounts and thus do not result in any federal reimbursement payments.

Under the 2015 Act, insurance companies must offer coverage for losses due to certified acts of terrorism in their workers compensation policies. Moreover, the workers compensation laws of the various states generally do not permit the exclusion of coverage for losses arising from acts of terrorism, including terrorism that involves the use of nuclear, biological, radioactive or chemical agents. In addition, state law prohibits us

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from limiting our workers compensation insurance losses arising from any one catastrophe or any one claimant. We have reinsurance protection in our current reinsurance treaty program that affords coverage for up to $70 million for losses arising from conventional terrorism. This coverage expires January 1, 2017. Amerisafe s 2016 Catastrophe excess of loss layer for loss occurrences greater than $10 million also added coverage for losses caused by nuclear, biological, chemical and radiological attacks, subject to the deductibles, retentions, definitions and aggregate limits. This coverage was renewed for 2016 and expires on January 1, 2017.

Technology

We view our information systems as an integral part of our operations. We make substantial investments in improving our systems on an ongoing basis. We provide our field premium auditors, field safety professionals and field case managers with computer and communication equipment to efficiently complete services. We also deploy online solutions for our policyholders to enable timely and efficient premium payments and claims reporting, and for our agents to improve collaboration and exchange of data in the underwriting process. Our information technology employees perform end-user support, systems development, and infrastructure operation and maintenance with limited assistance from outside vendors.

Competition

The insurance industry, in general, is highly competitive and there is significant competition in the workers compensation segment of the industry. Competition in the insurance business is based on many factors, including premium rates, policy terms, coverage availability, claims management, safety services, payment terms, types of insurance offered, overall financial strength and financial ratings assigned by independent rating organizations, such as A.M. Best. Some of the insurers with which we compete have significantly greater financial, marketing and management resources than we do. We may also compete with new market entrants in the future.

We believe the workers compensation market for the hazardous industries we target is more fragmented and to some degree less competitive than other segments of the workers compensation market. Our competitors include other insurance companies, state insurance pools and self-insurance funds. Overall, we estimate that more than 300 insurance companies participate in the workers compensation market. The insurance companies with which we compete vary by state and by the industries we target. These market conditions are also impacted by lower estimated loss costs adopted by a number of states in which we do business.

Our competitive advantages include our safety service and claims management practices, our A.M. Best rating and our ability to reduce claims through implementation of our work safety programs. In addition, we believe that our insurance is competitively priced and our premium rates are typically lower than those for policyholders assigned to the state insurance pools, allowing us to provide a viable alternative for policyholders in those pools.

Employees

As of December 31, 2015, we had 449 full-time employees and 2 part-time employees. None of our employees are subject to collective bargaining agreements. We believe that our employee relations are good.

Regulation

Holding Company Regulation

Nearly all states have enacted legislation that regulates insurance holding company systems. Each insurance company in a holding company system is required to register with the insurance supervisory agency of its state of domicile and furnish information concerning the operations of companies within the holding company system that may materially affect the operations, management or financial condition of the insurers within the system. Under these laws, the respective state insurance departments may examine us at any time, require disclosure of material transactions and require prior notice of or approval for certain transactions. All transactions within a holding company system affecting an insurer must have fair and reasonable terms and are subject to other standards and requirements established by law and regulation.

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Change of Control

The insurance holding company laws of nearly all states require advance approval by the respective state insurance departments of any change of control of an insurer. 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 any entity that controls a domestic insurance company. In addition, insurance laws in many states contain provisions that require pre-notification to the insurance commissioners of a change of control of a non-domestic insurance company licensed in those states. Any future transactions that would constitute a change of control of American Interstate, Silver Oak Casualty or American Interstate of Texas, including a change of control of AMERISAFE, would generally require the party acquiring control to obtain the prior approval of the department of insurance in the state in which the insurance company being acquired is incorporated and may require pre-notification in the states where pre-notification provisions have been adopted. Obtaining these approvals may result in the material delay of, or deter, any such transaction.

These laws may discourage potential acquisition proposals and may delay, deter or prevent a change of control of AMERISAFE, including through transactions, and in particular unsolicited transactions, that some or all of the shareholders of AMERISAFE might consider to be desirable.

State Insurance Regulation

Insurance companies are subject to regulation and supervision by the department of insurance in the state in which they are domiciled and, to a lesser extent, other states in which they conduct business. American Interstate and Silver Oak Casualty are primarily subject to regulation and supervision by the Nebraska Department of Insurance. American Interstate of Texas is primarily subject to regulation and supervision by the Texas Department of Insurance and Workers Compensation Commission. These state agencies have broad regulatory, supervisory and administrative powers, including among other things, the power to grant and revoke licenses to transact business, license agencies, set the standards of solvency to be met and maintained, determine the nature of, and limitations on, investments and dividends, approve policy forms and rates in some states, periodically examine financial statements, determine the form and content of required financial statements and periodically examine market conduct.

Detailed annual and quarterly financial statements and other reports are required to be filed with the state insurance departments in all states in which we are licensed to transact business. The financial statements of American Interstate, Silver Oak Casualty and American Interstate of Texas are subject to periodic examination by the department of insurance in each state in which they are licensed to do business.

In addition, many states have laws and regulations that limit an insurer s ability to withdraw from a particular market. For example, states may limit an insurer s ability to cancel or not renew policies. Furthermore, certain states prohibit an insurer from withdrawing one or more lines of business from the state, except pursuant to a plan that is approved by the state insurance department. The state insurance department may disapprove a plan that may lead to market disruption. Laws and regulations that limit cancellation and non-renewal and that subject program withdrawals to prior approval requirements may restrict our ability to exit unprofitable markets.

Insurance agencies are also subject to regulation and supervision by the state insurance departments in the states in which they are licensed. Our wholly owned subsidiary, Amerisafe General Agency, Inc., is licensed as an insurance agent in 28 states and as a managing general insurance agency in 15 states. Amerisafe General Agency is domiciled in Louisiana and is primarily subject to regulation and supervision by the Louisiana Department of Insurance, which regulates the solicitation of insurance and the qualification and licensing of agents and agencies that may desire to conduct business in Louisiana.

State Insurance Department Examinations

We are subject to periodic examinations by state insurance departments in the states in which we operate. The Nebraska insurance department generally examines its domiciliary insurance companies every five years. The Texas insurance department generally conducts examinations of its domiciliary insurance companies on a triennial basis.

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American Interstate Insurance Company and Silver Oak Casualty, Inc. underwent a Nebraska insurance department examination in 2014 that covered calendar years 2009 through 2013. American Interstate Insurance Company of Texas underwent an examination in 2014 that covered calendar years 2010 through 2013.

Guaranty Fund Assessments

In most of the states where we are licensed to transact business, there is a requirement that property and casualty insurers doing business in that state participate in a guaranty association, which is organized to pay contractual benefits owed under insurance policies issued by impaired, insolvent or failed insurers. These associations levy assessments, up to prescribed limits, on all member insurers in a particular state on the basis of the proportionate share of the premium written by member insurers in the lines of business in which the impaired, insolvent or failed insurer is engaged. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets.

Property and casualty insurance company insolvencies or failures may result in additional security fund assessments to us at some future date. At this time, we are unable to determine the impact, if any, such assessments may have on our financial position or results of operations. We have established liabilities for guaranty fund assessments with respect to insurers that are currently subject to insolvency proceedings.

Residual Market Programs

Many of the states in which we conduct business or intend to conduct business require that all licensed insurers participate in a program to provide workers compensation insurance to those employers who have not or cannot obtain coverage from a carrier on a negotiated basis. The level of required participation in such programs is generally determined by calculating the volume of our voluntary business in that state as a percentage of all voluntary business in that state by all insurers. The resulting factor is the proportion of premium we must accept as a percentage of all of premiums in policies included in that state s residual market program.

Companies generally can fulfill their residual market obligations by either issuing insurance policies to employers assigned to them, or participating in a reinsurance pool where the results of all policies provided through the pool are shared by the participating companies. We utilize both methods, depending on management s evaluation of the most cost-efficient method to adopt in each state that allows a choice of assigned risk or participation in a pooling arrangement. In 2015, we had assigned risks in four states: Alabama, Alaska, North Carolina and Virginia.

Second Injury Funds

A number of states operate trust funds that reimburse insurers and employers for claims paid to injured employees for aggravation of prior conditions or injuries. The state-managed trust funds are funded through assessments against insurers and self-insurers providing workers compensation coverage in the applicable state. Our recoveries from state-managed trust funds for the years ended December 31, 2015, 2014 and 2013 were $5.8 million, $6.8 million and $6.0 million, respectively. Our cash paid for assessments to state-managed trust funds for the years ended December 31, 2015, 2014 and 2013 was $2.1 million, $1.9 million and $2.3 million, respectively. We accrue for second injury funds relative to historical paid amounts.

Dividend Limitations

Under Nebraska law, without the prior approval of the Nebraska Director of Insurance, American Interstate and Silver Oak Casualty cannot pay dividends to their shareholder that exceed the greater of (a) 10% of statutory surplus as of the previous year end or (b) or statutory net income, excluding realized investment gains, for the preceding 12-month

period. However, net income from the previous two calendar years may be carried forward to the extent that it has not already been paid out as dividends. Further, under Texas law, without the prior approval of the Texas Commissioner of Insurance, American Interstate of Texas cannot pay dividends to its shareholder in excess of the greater of (x) 10% of statutory surplus, or (y) statutory net income, for the preceding 12-month period.

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Federal Law and Regulations

For the year ended December 31, 2015, we derived 2.1% of our voluntary in-force premiums from employers engaged in the maritime industry. As a provider of workers compensation insurance for employers engaged in the maritime industry, we are subject to the United States Longshore and Harbor Workers Compensation Act, or the USL&H Act, and the Merchant Marine Act of 1920, or Jones Act. We are also subject to regulations related to the USL&H Act and the Jones Act.

The USL&H Act, which is administered by the U.S. Department of Labor, generally covers exposures on the navigable waters of the United States and in adjoining waterfront areas, including exposures resulting from stevedoring. The USL&H Act requires employers to provide medical benefits, compensation for lost wages, and rehabilitation services to longshoremen, harbor workers and other maritime workers who may suffer injury, disability or death during the course and scope of their employment. The Department of Labor has the authority to require us to make deposits to serve as collateral for losses incurred under the USL&H Act.

The Jones Act is a federal law, the maritime employer provisions of which provide injured offshore workers, or seamen, with a remedy against their employers for injuries arising from negligent acts of the employer or co-workers during the course of employment on a ship or vessel.

Privacy Regulations

In 1999, Congress enacted the Gramm-Leach-Bliley Act, which, among other things, protects consumers from the unauthorized dissemination of certain personal information. Subsequently, a majority of states have implemented additional regulations to address privacy issues. These laws and regulations apply to all financial institutions, including insurance companies, and require us to maintain appropriate policies and procedures for managing and protecting certain personal information of our policyholders and to fully disclose our privacy practices to our policyholders. We may also be exposed to future privacy laws and regulations, which could impose additional costs and impact our results of operations or financial condition. In 2000, the National Association of Insurance Commissioners, or the NAIC, adopted the Privacy of Consumer Financial and Health Information Model Regulation, which assisted states in promulgating regulations to comply with the Gramm-Leach-Bliley Act. In 2002, to further facilitate the implementation of the Gramm-Leach-Bliley Act, the NAIC adopted the Standards for Safeguarding Customer Information Model Regulation. Several states have now adopted similar provisions regarding the safeguarding of policyholder information. We have established policies and procedures intended to ensure that we are in compliance with the Gramm-Leach-Bliley related privacy requirements.

Federal and State Legislative and Regulatory Changes

From time to time, various regulatory and legislative changes have been proposed in the insurance industry. Among the proposals that have in the past been or are at present being considered are the possible introduction of federal regulation in addition to, or in lieu of, the current system of state regulation of insurers and proposals in various state legislatures (some of which proposals have been enacted) to conform portions of their insurance laws and regulations to various model acts adopted by the NAIC. We are unable to predict whether any of these laws and regulations will be adopted, the form in which any such laws and regulations would be adopted or the effect, if any, these developments would have on our operations and financial condition.

For information on the Terrorism Risk Act, see Reinsurance Terrorism Reinsurance.

The National Association of Insurance Commissioners

The NAIC is a group formed by state insurance commissioners to discuss issues and formulate policy with respect to regulation, reporting and accounting of insurance companies. Although the NAIC has no legislative authority and insurance companies are at all times subject to the laws of their respective domiciliary states and, to a lesser extent, other states in which they conduct business, the NAIC is influential in determining the form in which such laws are enacted. Model insurance laws, regulations and guidelines, which we refer to as the Model

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Laws, have been promulgated by the NAIC as a minimum standard by which state regulatory systems and regulations are measured. Adoption of state laws that provide for substantially similar regulations to those described in the Model Laws is a requirement for accreditation by the NAIC. The NAIC provides authoritative guidance to insurance regulators on statutory accounting issues by promulgating and updating a codified set of statutory accounting practices in its *Accounting Practices and Procedures* manual. The Nebraska and Texas legislatures have adopted these codified statutory accounting practices.

Under Nebraska law, American Interstate and Silver Oak Casualty are each required to maintain minimum capital and surplus of $2.0 million. Under Texas law, American Interstate of Texas is required to maintain minimum capital and surplus of $5.0 million. Property and casualty insurance companies are also subject to certain risk-based capital requirements by the NAIC. Under those requirements, the amount of capital and surplus maintained by a property and casualty insurance company is determined based on the various risk factors related to it. As of December 31, 2015, American Interstate, Silver Oak Casualty, and American Interstate of Texas exceeded the minimum risk-based capital requirements.

The key financial ratios of the NAIC s Insurance Regulatory Information System, or IRIS, which ratios were developed to assist insurance departments in overseeing the financial condition of insurance companies, are reviewed by experienced financial examiners of the NAIC and state insurance departments to select those companies that merit highest priority in the allocation of the regulators resources. IRIS identifies 13 industry ratios and specifies usual values for each ratio. Departure from the usual values on four or more of the ratios can lead to inquiries from individual state insurance commissioners as to certain aspects of an insurer s business.

The 2015 IRIS results for American Interstate Insurance Company were with expected values. The 2015 IRIS results for Silver Oak Casualty and American Interstate Insurance Company of Texas were within expected values for 12 of the 13 ratios. The investment yield ratios were outside the expected range by two tenths of one percent and six tenths of one percent, respectively. This occurred because current low interest rates affected the reinvestment rate for our investment portfolio.

Statutory Accounting Principles

Statutory accounting principles, or SAP, are a basis of accounting developed to assist insurance regulators in monitoring and regulating the solvency of insurance companies. SAP is primarily concerned with measuring an insurer s surplus as regards to policyholders. Accordingly, statutory accounting focuses on valuing assets and liabilities of insurers at financial reporting dates in accordance with appropriate insurance law and regulatory provisions applicable in each insurer s domiciliary state.

Generally accepted accounting principles, or GAAP, are concerned with a company s solvency, but are also concerned with other financial measurements, principally income and cash flows. Accordingly, GAAP gives more consideration to appropriate matching of revenue and expenses and accounting for management s stewardship of assets than does SAP. As a direct result, different assets and liabilities and different amounts of assets and liabilities will be reflected in financial statements prepared in accordance with GAAP as compared to SAP.

Statutory accounting principles established by the NAIC and adopted in part by Nebraska and Texas insurance regulators, determine, among other things, the amount of statutory surplus and statutory net income of American Interstate, Silver Oak Casualty and American Interstate of Texas and thus determine, in part, the amount of funds that are available to pay dividends to AMERISAFE.

Website Information

Our corporate website is located at *www.amerisafe.com*. Our Annual Report to Shareholders, annual proxy statement and related proxy card will be made available on our website at the same time they are mailed to shareholders. Our quarterly reports on Form 10-Q, periodic reports on Form 8-K and amendments to those reports that we file or furnish pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are

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available through our website, free of charge, as soon as reasonably practicable after they have been electronically filed or furnished to the Securities and Exchange Commission, or the SEC. Our website also provides access to reports filed by our directors, executive officers and certain significant shareholders pursuant to Section 16 of the Securities Exchange Act of 1934. In addition, our Corporate Governance Guidelines, Code of Business Conduct and Ethics, Policy Regarding Communications with the Board of Directors, Policy Regarding Shareholder Recommended Director Candidates, and charters for the standing committees of our board of directors are available on our website as well as other shareholder communications. The information on our website is not incorporated by reference into this report. In addition, the SEC maintains a website, *www.sec.gov*, which contains reports, proxy and information statements and other information that we file electronically with the SEC.

Executive Officers of the Registrant

The table below sets forth information about our executive officers and key employees as of February 26, 2015.

Name	Age	Position
Executive Officers		
C. Allen Bradley, Jr.	64	Executive Chairman
G. Janelle Frost.	45	President and Chief Executive Officer
Neal A. Fuller.	53	Executive Vice President and Chief Financial Officer
Vincent J. Gagliano	43	Executive Vice President and Chief Technology Officer
Key Employees		
Brendan D. Gau	41	Senior Vice President, Chief Investment Officer
Kelly R. Goins	50	Senior Vice President, Underwriting Operations
Leon J. Lagneaux	64	Senior Vice President, Safety Operations
Henry O. Lestage, IV	55	Senior Vice President, Claims Operations
David R. Morton	45	Senior Vice President, Sales and Marketing
Kathryn H. Shirley	50	Senior Vice President, General Counsel and Secretary

C. Allen Bradley, Jr., our Executive Chairman, has served as Chairman of our board of directors since October 2005 and as a Director since June 2003. From December 2003 until April 2015 he served as Chief Executive Officer. From November 2002 to August 2010 he served as President. From November 2002 until December 2003 he served as our Chief Operating Officer. Since joining our company in 1994, Mr. Bradley has had principal responsibility for the management of our underwriting operations (December 2000 through June 2005) and safety services (September 2000 through November 2002) and has served as our General Counsel (September 1997 through December 2003) and Secretary (September 1997 through November 2002). Prior to joining our company, he was engaged in the private practice of law.

G. Janelle Frost has served as our Chief Executive Officer since April 2015 and President since September 2013. Prior to becoming our Chief Executive Officer, Mrs. Frost served as Chief Operating Officer from May 2013 to April 2015. She served as our Executive Vice President and Chief Financial Officer from November 2008 to April 2013, our Controller from May 2004 to November 2008 and Vice President from May 2006 to November 2008. She has been employed with our company since 1992 and served as Assistant Vice President from May 2004 to May 2006 and Deputy Controller from 1998 to April 2004.

Neal A. Fuller has served as Executive Vice President and Chief Financial Officer since September 2015. Mr. Fuller served in multiple leadership positions with Safeco Corporation from 1988 to 2009, ending as Senior Vice President Finance and Treasurer. Prior to joining our company, Mr. Fuller served as Senior Vice President and Chief Financial Officer of ICW Group from 2010 to 2011 and Senior Vice President and Chief Financial Officer of SeaBright Holdings, Inc. from 2011 to 2013.

Vincent J. Gagliano has served as our Executive Vice President and Chief Technology Officer since January 2013. He has been employed with our company since 2001. He previously served as Senior Vice

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President of Information Technology from September 2009 to January 2013, Vice President, Operations Analysis from January 2008 to September 2009, Assistant Vice President of Business Intelligence from July 2005 to December 2008, Director of Business Intelligence from April 2004 to July 2005 and Senior Business Analyst from July 2001 to April 2004.

Brendan D. Gau has served as our Chief Investment Officer since joining the Company in 2009. Prior to joining our company, Mr. Gau was employed by AIM Capital Management, where he held the positions of Financial Analyst, Portfolio Analyst and Senior Portfolio Manager from 1996 until 2009.

Kelly R. Goins has served as our Senior Vice President, Underwriting Operations since March 2005. She has been employed with our company since 1986. She previously served as Vice President, Underwriting Operations from 2000 until March 2005.

Leon J. Lagneaux has served as our Senior Vice President, Safety Operations since March 2005. He has been employed with our company since 1994. He previously served as Vice President, Safety Operations from 1999 until March 2005.

Henry O. Lestage, IV has served as our Senior Vice President, Claims Operations since September 2000. He has been employed with our company since 1987. He previously served as Vice President, Claims Operations from 1998 until 2000.

David R. Morton has served as Senior Vice President, Sales and Marketing since April 2015. Prior to joining our company, Mr. Morton served in various sales leadership roles with EMPLOYERS Services, Inc., a mono-line workers compensation insurance carrier, including Director of Client Relations from 2007 to 2010, Vice President of Sales, Strategic Partnerships and Alliances from 2010 to 2014 and most recently as Vice President of Sales Excellence from September 2014 to April 2015.

Kathryn H. Shirley has served as Senior Vice President, General Counsel and Secretary since May 2012 when she joined our company. From 2009 through May 2012 she practiced law at Christian & Small LLP. From 2000 until 2008 she was employed as an Insurance Regulatory Compliance Manager with United Investors Life Insurance Company and Liberty National Life Insurance Company, subsidiaries of Torchmark Corporation.

Item 1A. Risk Factors.

In evaluating our Company, the factors described below should be considered carefully. The occurrence of one or more of these events could significantly and adversely affect our business, prospects, financial condition, results of operations and cash flows.

Risks Related to Our Business

The workers compensation insurance industry is cyclical in nature, which may affect our overall financial performance.

The financial performance of the workers compensation insurance industry has historically fluctuated with periods of lower premium rates and excess underwriting capacity resulting from increased competition followed by periods of higher premium rates and reduced underwriting capacity resulting from decreased competition. 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 this market 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 expect these cyclical patterns will cause our revenues and net income to fluctuate, which may cause the price of our common stock to be more volatile.

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Current economic conditions could adversely affect our financial condition and results of operations.

The economic recovery from the recession of 2008 through 2010 has been sluggish. Negative trends in business investment, consumer confidence and spending, the significant declines and volatility of the capital markets, the availability of credit and the rate of unemployment can adversely affect our business. A continuation of the current economic environment could further adversely impact our growth and profitability. Although we continue to closely monitor market conditions, we cannot predict future conditions or their impact on our premium volume, the value of our investment portfolio and our financial performance. As a result of these existing economic conditions, we could experience future decreases in business activity and incur additional realized and unrealized losses in our investment portfolio, both of which could adversely affect our financial condition and results of operations.

If more states approve non-subscriber progams, the demand for workers compensation insurance could be significantly impacted.

Workers compensation insurance is required by law with few exceptions. States such as Texas and Oklahoma offer employers the option to non-subscribe to the workers compensation system. By non-subscribing, employers lose the exclusive remedy protection afforded those that do subscribe. Texas s program has been in existence since 1913 and Oklahoma s program began in 2013. A number of states have proposed legislation for similar programs which could threaten the demand for the workers compensation product we offer.

If we do not appropriately establish our premium rates, our results of operations will be adversely affected.

In general, the premium rates for our insurance policies are established when coverage is initiated and, therefore, before all of the underlying costs are known. Like other workers compensation insurance companies, we rely on estimates and assumptions in setting our premium rates. Establishing adequate rates is necessary to generate sufficient revenue to offset losses, loss adjustment expenses and other underwriting expenses, and to earn an underwriting profit. If we fail to accurately assess the risks that we assume, we may fail to charge adequate premium rates to cover our losses and expenses, which could reduce our net income and cause us to become unprofitable. For example, when initiating coverage on a policyholder, we estimate future claims expense based, in part, on prior claims information provided by the policyholder s previous insurance carriers. If this prior claims information is not accurate, we may underprice our policy by using claims estimates that are too low. As a result, our actual costs for providing insurance coverage to our policyholders may be significantly higher than our premiums. In order to set premium rates appropriately, we must:

collect and properly analyze a substantial volume of data;

develop, test and apply appropriate rating formulae;

closely monitor and timely recognize changes in trends; and

project both frequency and severity of losses with reasonable accuracy.

We must also implement our pricing accurately in accordance with our assumptions. Our ability to undertake these efforts successfully, and as a result set premium rates accurately, is subject to a number of risks and uncertainties,

principally:

- insufficient reliable data;
- incorrect or incomplete analysis of available data;
- uncertainties generally inherent in estimates and assumptions;
- the complexity inherent in implementing appropriate rating formulae or other pricing methodologies;
- costs of ongoing medical treatment;

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uncertainties inherent in accurately estimating retention, investment yields, and the duration of our liability for loss and loss adjustment expenses; 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.

We operate in a highly competitive industry and may lack the financial resources to compete effectively.

There is significant competition in the workers compensation insurance industry. We believe that our competition in the hazardous industries we target is fragmented and not dominated by one or more competitors. We compete with other insurance companies, state insurance pools and self-insurance funds. Many of our existing and potential competitors are significantly larger and possess greater financial, marketing and management resources than we do. Moreover, a number of these competitors offer other types of insurance in addition to workers compensation and can provide insurance nationwide.

We offer workers compensation insurance. We have no current plans to focus our efforts on offering other types of insurance. As a result, negative developments in the economic, competitive or regulatory conditions affecting the workers compensation insurance industry could have an adverse effect on our financial condition and results of operations. Negative developments in the workers compensation insurance industry could have a greater effect on insurance companies that do not sell multiple types of insurance.

We compete on the basis of many factors, including coverage availability, claims management, safety services, payment terms, premium rates, policy terms, types of insurance offered, overall financial strength, financial ratings and reputation. If any of our competitors offer premium rates, policy terms or types of insurance that are more competitive than ours, we could lose market share. No assurance can be given that we will maintain our current competitive position in the markets in which we currently operate or that we will establish a competitive position in new markets into which we may expand.

If we cannot sustain our relationships with independent agencies, we may be unable to operate profitably.

We market a substantial portion of our workers compensation insurance through independent agencies. As of December 31, 2015, independent agencies produced 97.0% of our voluntary in-force premiums. No independent agency accounted for more than 1.3% of our voluntary in-force premiums at that date. Independent agencies are not obligated to promote our insurance and may sell insurance offered by our competitors. As a result, our continued profitability depends, in part, on the marketing efforts of our independent agencies and on our ability to offer workers compensation insurance and maintain financial strength ratings that meet the requirements of our independent agencies and their policyholders.

Technology breaches or failures, including those resulting from a malicious cyber attack on us or our policyholders and medical providers, could disrupt or otherwise negatively impact our business.

We rely on information technology systems to process, transmit, store and protect the electronic information, financial data and proprietary models that are critical to our business. Furthermore, a significant portion of the communications between our employees, our policyholders and medical providers depend on information technology and electronic information exchange. Like all companies, our information technology systems are vulnerable to data breaches,

interruptions or failures due to events that may be beyond our control, including natural disasters, theft, terrorist attacks, computer viruses, hackers and general technology failures.

We have established and implemented security measures, controls and procedures in an effort to safeguard our information technology systems and to prevent unauthorized access to these systems and any data processed and/or stored in these systems. Despite these safeguards, disruptions to and breaches of our information technology systems are possible and may negatively impact our business.

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Although we have experienced no known or threatened cases involving unauthorized access to our information technology systems and data or unauthorized appropriation of such data to date, we have no assurance that such technology breaches will not occur in the future.

Our loss reserves are based on estimates and may be inadequate to cover our actual losses.

We record reserves for estimated losses under insurance policies we write and for loss adjustment expenses related to the investigation and settlement of claims. Our reserves for loss and loss adjustment expenses represent the estimated cost of all reported and unreported loss and loss adjustment expenses incurred and unpaid at any given point in time based on known facts and circumstances. Reserves are based on estimates of the most likely ultimate cost of individual claims. These estimates are inherently uncertain.

Our pre-tax income for any period is impacted by establishing reserves for new claims as well as changes in estimates for previously reported losses. Our focus on writing workers compensation insurance for employers engaged in hazardous industries results in our experiencing fewer, but more severe, claims. The ultimate cost of resolving severe claims is difficult to predict, particularly in the period shortly after the injury occurs. Substantial judgment is required to determine the relevance of our historical experience and industry information under current facts and circumstances. The interpretation of this historical data can be impacted by external forces, principally frequency and severity of unreported claims, length of time to achieve ultimate settlement of claims, inflation in medical costs and wages, insurance policy coverage interpretations, jury determinations, and legislative changes. Accordingly, our r