UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

HOLLY DULSKY, individually and on behalf of all persons similarly situated, Plaintiff, vs. WILLIAM M. WORTHY, II; DAVID L. CLARK; LOUIS DeLUCA; GARY L. KARNS, JR.; DAVID L. NELLSON a/k/a DAVID NELSON; VIKING ADMINISTRATORS, LLC; ARNOLD KATZ a/k/a ARNIE KATZ; UNITED STATES CONTRACTORS TRUST; IRG BROKERAGE, LLC d/b/a INSURANCE RESOURCE GROUP; INTEGRATED INSURANCE MARKETING, INC.; REAL BENEFITS ASSOCIATION, LLC, Defendants.	:	Civil Action No. **CLASS ACTION COMPLAINT** **JURY TRIAL DEMANDED**

Plaintiff, Holly Dulsky, residing at 24 Owens Wedge Lane, Benton, Pennsylvania, individually and on behalf of all persons similarly situated, by her attorney, Gary Martin Meyers, Esq., for her Complaint, alleges as follows:

JURISDICTION AND VENUE

1. This is an action seeking damages under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961 et. seq., and therefore a federal question exists. Accordingly, both subject matter and personal jurisdiction properly lie in this Court pursuant to 28 U.S.C. § 1331. Supplemental jurisdiction exists under 28

U.S.C. § 1367 over those state law claims not giving rise to an independent basis for Federal jurisdiction.

2. Venue is proper in this Court as at least two of the principal defendants, including defendants David L. Clark and Real Benefits Association, LLC, reside and/or have their principal places of business within this Judicial District, and because, as set forth below, several of the Defendants regularly and systematically do business in this District, and numerous pertinent events giving rise to the claims at issue occurred in this District.

THE PARTIES

3. Plaintiff, Holly Dursky, is a resident of Benton, Pennsylvania. She is the purchaser of what was represented to her as a valid "medical insurance policy," which she purchased on or about June 1, 2009, from defendant United States Contractors Trust.

4. Defendant William M. Worthy, II ("Worthy") is a resident of Isle of Palms, South Carolina, 29451-2742.

5. Defendant David L. Clark ("Clark") is a resident of New Jersey, having a last known address of One Beach Trail, Morristown, New Jersey 07960.

6. Clark is a principal in an entity that goes by the name of Real Benefits Association, LLC, and which has offices in New Jersey and New York.

7. Upon information and belief, Clark owns 100% of Real Benefits Assocation, LLC.

8. Defendant Real Benefits Assocation, LLC ("RBA") is a New Jersey Limited Liability Company which, through its offices at 75 Hardscrabble Road, Suite

202, P.O. Box 74, in Basking Ridge, New Jersey 07920, does business in the State of New Jersey.

9. Defendant IRG Brokerage, LLC is a New York Limited Liability Company located at 20 Madison Avenue, Valhalla, New York 10595.

10. IRG Brokerage, LLC does business in New York as Insurance Resource Group ("IRG").

11. Defendant Louis DeLuca ("DeLuca") is an individual who resides at 1106 Smith Ridge Road, New Canaan, Connecticut 06840.

12. Upon information and belief, DeLuca owns 100% of IRG.

13. Defendant Gary L. Karns, Jr. ("Karns") resides at 1145 Highbrook, #411, Akron, Ohio 44301.

14. Defendant Integrated Insurance Marketing, Inc. ("IIM") is an Ohio corporation owned and/or controlled entirely by Defendants, Karns and DeLuca.

15. Defendant United States Contractors Trust ("USCT") is a Delaware statutory trust, with an address of 10293 Lexington Lakes Boulevard South, Boynton Beach, Florida 33436.

16. Defendant Arnie Katz ("Katz") is an individual residing or conducting business at 731 South Highway 101, #2E, Solana Beach, California 92075.

17. Defendant David L. Nellson ("Nellson") a/k/a David Nelson is the "senior trustee" of USCT.

18. Defendant David L. Nellson is believed to utilize other aliases as well.

19. Defendant Viking Administrators, LLC ("Viking") is a Tennessee Limited Liability Company owned and controlled by defendant Worthy, with an address of 5201 Kingston Park, Knoxville, Tennessee 37919.

FACTS COMMON TO ALL CAUSES OF ACTION

20. Defendants are part of a nationwide, association-in-fact enterprise that has existed and operated for at least the last ten years. The purpose of the enterprise is the misappropriation and/or theft of premium dollars from members of the public by "selling" non-existent limited liability health insurance and/or medical insurance and by manipulating the claims process so that those members of the public paying premiums do not discover that they have been (and are being) defrauded until after substantial premium payments have been made, and substantial medical expenses incurred, under the false belief that the said expenses are "covered" by one or more of defendants' fraudulent, and/or nonexistent "policies" of medical insurance. Throughout its existence, the enterprise has operated by creating a non-existent master policy, and/or by having policies issue to and by ficticious insurers, and by then selling coverage to association members under the purported master policy through the use of high pressure techniques and false representations, and then by manipulating the claim process by delaying claims so that additional premiums can be collected. Ultimately the claims are denied, or simply ignored, leaving the "insureds" not only out the premium dollars they have paid, but legally responsible for their uncovered medical bills as well. At all times the enterprise preyed upon unsuspecting members of the public who relied upon their false representations, and/or upon members of various "associations" through whom the defendants marketed their fraudulent "insurance policies." Upon information and belief,

defendants have sold their fraudulent and fictitious insurance policies in at least a dozen states. Once their fraud is uncovered, defendants change the name of their fictitious insurance "carrier," assume new identities, and repeat the process. Defendants Worthy, Clark, DeLuca, Katz and USCT are not licensed to sell health insurance products to individuals or to association members however, upon information and belief, they have been doing so for years, and continue to do so at the present time. Upon information and belief, William Worthy (a/k/a William Worrthy, II) presently is the ringleader of defendants' enterprise.

21. On or about June 1, 2009, plaintiff Holly Dulsky purchased a "policy" of medical insurance from defendant USCT, for which insurance did not exist. She made the following payments to USCT, for purchase of what she believed to be a valid medical insurance policy, in the following amounts, and on the following dates:

$241.96, paid on May 7th, 2010;

$125.00, paid on May 7th, 2010;

$241.96, paid on June 22, 2010;

$241.96, paid on July 22, 2010;

After selling her this "insurance" policy, and collecting her "premiums" for approximately three months, USCT manipulated the "claims process," and denied valid claims she submitted, as well as issuing a check or checks to one or more of her health care providers, that was returned for "insufficient funds." Upon information and belief, defendants USCT and Worthy, acting in concert with some or all of the other defendants, utilized the United States Postal Service and/or an interstate telephone system to solicit

the sale of their phony "insurance" policy to plaintiff, and to transmit to her false "policy" documents.

22. On October 14, 2004, the New Jersey Department of Insurance charged a member of defendants' association-in-fact enterprise, defendant Clark, with selling health insurance through "illegitimate sham unions, submitting false documents to insurers, improperly withholding insurance premiums and unlawfully charging insurers with association or union dues." In 2009, Clark signed a Consent Order admitting that from 2001 through 2004 he sold group health insurance through a purported union that was later determined not to be an actual labor organization, and that he failed to remit $91,620 in premium payments to insurers, which he misappropriated, that he failed to disclose health insurance premium amounts to insureds, failed to advise insureds that coverage was cancelled and/or did not exist (presumably so he could continue collecting premiums from them) and improperly co-mingled health insurance premiums with the dues of one or more Assocations. Clark's license to sell insurance in New Jersey was revoked by that Consent Order. Although he was enjoined from "soliciting insurance and/or health benefits of any kind in the State of New Jersey," upon information and belief he continued to represent himself as a seller of insurance, and continued to do so.

23. In 2005, another member of defendants' association-in-fact enterprise, defendant Worthy, sold "policies of health insurance" to members of the Transportation Services Association, which purported to be underwritten by TIG Premier Insurance Company. Like Clark, Worthy also did not remit the premiums he stole to any bona fide insurance company, and he failed to pay claims.

24. In March, 2006, the Nebraska Department of Insurance issued a cease and desist order to Worthy arising out of Worthy's company's sale of limited liability health insurance to Nebraska residents. Also in 2006, South Carolina, the State in which Worthy resides, revoked Worthy's insurance license for misappropriation, i.e., stealing of premium payments.

25. According to Missouri's Department of Insurance, in 2007, defendants Worthy, Clark, and RBA individually and in concert with others engaged in "junk fax" advertising and issued false and misleading advertising in which they falsely identified themselves as insurers, and failed to actually identify the "coverage" being purchased. The State of Missouri identified several individuals who were injured by Defendants' fraudulent scheme including one gentleman, identified only as "Consumer B," who in July of 2007 responded to an unsolicited fax advertising "low cost quality health insurance" and "free flu shots." After paying defendants $1,707 in premiums, defendants refused to provide him with "free flu shots," and retained all of his premium payments.

26. In November of 2008, the North Carolina Department of Insurance issued a final Consent Cease and Desist Order naming defendants Clark and RBA, arising out of RBA's selling of unauthorized limited liability medical health insurance plans purportedly insured by an unlicensed entity, Serve America, which was owned in part and/or controlled in part by defendant Worthy and his business associatiates.

27. In 2008 and/or 2009, DeLuca sold and conspired to sell Worthy's Serve America "insurance" to members of the Association of Independent Managers and he improperly retained premiums from those members for non-existent coverage. DeLuca touted that fraudulent AIM Insurance Program on the Internet.

28. In 2009, David C. Clark and RBA sold and solicited the purchase of health insurance on the Internet and in particular through the websites www.sdsfirst.com, www.atafirst.com, www.rba-ata.com, www.healthtoday.biz, www.servamericaltd.com, www.familyhealthresource.com, www.firstamericanhealthcare.com, and www.myatabenefits.com. Clark received premium payments from thousands of individuals throughout the United States, through these websites, and failed to provide these individuals with the purchased insurance.

29. Defendant Katz is an unlicensed individual who sells "insurance products" manufactured by defendants Worthy and Clark through a website www.accesshealth.com and other similar sites.

30. The Tennessee Department of Insurance in March of 2010, filed a Petition naming William M. Worthy as a defendant, as well as other individuals and trade associations, alleging that from March 2008 until October 2009, policies of limited medical liability insurance were issued to residents of Tennessee. The Petition alleges that the purported Master Policy was issued to defendnat RBA which was not licensed as an insurance company or administrator in Texas. The policy allegedly issued to RBA was then marketed by defendants Worthy and Clark through the Internet.

31. On June 26, 2009, defendant worthy incorporated defendant Viking so that he could utilize the entity to perpetuate insurance fraud. It was the intent of Worthy to have Viking act as a fictitious third party administrator to delay and deny claims of insureds.

32. In October of 2009, Clark approached an individual by the name of Kevin Dunn, in Dunn's capacity as agent for an association known as "CEO Clubs."

33. Clark told Dunn that he and his partner, defendant Worthy, were entering into contractual arrangements with a U.S.-domiciled health insurer that held certificates of authority to issue limited liability medical insurance in most states.

34. In October 2009, defendant Clark met with Joe Mancuso, an executive with CEO Clubs, at CEO Clubs' headquarters in New York City, to discuss defendant Clark's and Worthy's marketing a limited liability medical program to CEO Clubs' members. Clark represented that the program was going to be backed by insurance issued by Phoenix Insurance Company.

35. In November of 2009, defendant Clark attended a meeting at CEO Clubs' headquarters in New York City as part of his and Worthy's performing "due diligence" for the program.

36. In or about November 2009, Clark and defendant DeLuca met with Kevin Dunn at the Westchester Country Club in Westchester, New York to discuss the marketing of a limited liability policy for CEO Clubs' members allegedly to be backed by insurance issued through Phoenix.

37. On December 18, 2009, defendants Worthy, Clark, and DeLuca met with Kevin Dunn at La Bernadin Restaurant in Manhattan to discuss the Limited Medical Liability Program, and to finalize the arrangements for the program. At that meeting, Worth told all present that he was going to be the program manager, that his partner David Clark was going to be the co-program manager, that Clark's company, RBA, was going to perform administrative and marketing tasks, and that defendants DeLuca and IRG were going to perform customer service and premium billing.

38. As a consequence of that meeting, Worthy, Clark and DeLuca were provided with the opportunity to offer a limited medical liability policy allegedly to be issued by Phoenix Insurance Company to members of CEO Clubs, residing in New York and other states. Clark and/or Worthy emailed what was purported to be a "Phoenix" Master Policy to CEO Clubs and CEO Benefits. That "policy" turned out to be a forgery, providing no coverage whatsoever. The delivery of that fraudulent policy constituted mail fraud and/or wire fraud.

39. Thereafter, Worthy, Clark, DeLuca, Katz and Karns utilized telephone lines, email, the internet and facsimile lines to recruit "insurance" customers – including members of the general public, such as the plaintiff in this action, as well as members of various associations. Although a policy did not exist, and thus coverage did not exist, defendants DeLuca and Katz arranged to collect premiums and association fees for the non-existent insurance coverage, and did so in a variety of ways including direct bank withdrawals, and the cashing of checks and money – all of which constituted larceny and/or bank fraud. Each solicitation of a prospective purchaser of insurance by telephone or internet was wire fraud, and each time a premium was accepted DeLuca and/or Katz committed larceny.

40. Concomitantly, DeLuca convinced various associations and other consumer groups to enter into a relationship with Integrated Insurance Marketing (IIM), owned and controlled by DeLuca and Karns, to solicit purchasers of defendants' fraudulent "insurance" from association and consumer group members.

41. Some or all of these associations and/or groups entered into an agreement with DeLuca and/or Insurance Resource Group (IRG), which is owned and/or controlled

by DeLuca. IRG collected premiums and other monies on behalf of associations and consumer groups, which it did not utilize to purchase valid insurance coverage on behalf of their members, and in so doing committed larceny.

42. In furtherance of defendants' association-in-fact enterprise, Clark, DeLuca and Katz published internet web sites in which they promoted a limited medical liability program allegedly insured by Phoenix, and other insurers, that they were offering to members of the general public, as well as to members of associations and consumer groups. Despite full knowledge of the fact that the Phoenix policy, and their other phony "policies" did not exist, defendants Worthy, Clark, Karns and DeLuca continued selling the "insurance," soliciting and collecting premium payments.

43. In effect, and in actuality, Clark, Karns, DeLuca and Katz and their companies committed larceny by selling medical insurance coverage that did not exist, and they committed fraud by knowingly selling what they alleged was "insurance," when they knew the "insurance" did not exist.

44. DeLuca and Karns, through IIM and/or IRG, controlled the marketing and premium collections, in connection with their fraudulent sales of medical and/or health "insurance." In order to market their fraudulent "policies," defendants DeLuca and Karns, by and through their companies, and as the alter ego of their companies, falsely represented to prospective purchasers of their "insurance" that a Master Policy existed, which would provide value to them in exchange for their premium payments, and through the use of emails, mail, facsimiles, websites and telephone lines Karns, DeLuca and Clark circulated these false representations to prospective purchasers, in order to induce them to

pay the premiums. Karns and DeLuca shared the stolen premiums with Worthy and Clark.

45. Clark, DeLuca and Karns established and controlled a "downstream" network of marketers, ending ultimately in retail producers and call centers (or "boiler rooms"), who sold their fraudulent insurance plans to the public both directly, and through various associations and consumer groups, and are responsible for the premiums stolen from them, including those stolen by Katz and his company, Access Now. DeLuca and/or Karns received a financial benefit for the use of these "boiler rooms."

46. As part and parcel of their pattern of fraud, DeLuca, Karns and Katz moved members of certain associations into other associations. For example, they moved members of numerous associations into the CEO Clubs' Insurance Program, falsely claiming orally over the telephone, on the internet, in emails and by the use of the mails, that a policy of master insurance actually existed. DeLuca, Karns and Katz stole the dues monies paid by these other associations, most or all of which had been earmarked for purchase of their fraudulent insurance policies, in the same way they misappropriated the premium payments of CEO Clubs members, as well as that of plaintiff and the members of the public.

47. In furtherance of this same scheme, in November 2009, Worthy and Clark represented to Dunn by telephone that CEO Clubs members were now covered by a policy issued by Town and Country Insurance Company. They did so, however, without the knowledge and authority of Town and Country Insurance. DeLuca and Karns, in furtherance of the criminal enterprise, and without confirming that a policy existed, issued certificates to association members falsely indicating that Town and Country

Insurance issued a policy. The mailing of the false certificates constituted acts of mail fraud.

48. In December of 2009, Worthy and Clark told Dunn by telephone that Phoenix NAIC number 25623, had issued a group limited medical benefit indemnity policy to CEO Clubs.

49. On January 6, 2010, Worthy, in furtherance of the fraudulent scheme, sent an email to Dunn, with a copy to Clark, purporting to list the jurisdictions in which Phoenix was licensed.

50. Worthy fraudulently sent Dunn by email a "certificate" purportedly issued by Star Group UK/Phoenix Insurance Company of Baltimore, Maryland, with the intent that Dunn would rely upon it, and Dunn did rely on it.

51. On December 11, 2009, David L. Nellson, the "senior trustee" of United States Contractors Trust (USCT), signed a letter addressed to Wilshire Holding Company, LLC. That letter stated: "Please accept this as our undertaking for the acceptance of the limited Mini Medical Plan produced by Wilshire Holding Company through Worldwide Family Benefits Association…USCT will provide a master certificate and policy to Worldwide Family Benefits Association and bind business written from November 1, 2009 based on TPA report supplied WWFBA from Star Group UK/The Phoenix Insurance Company (NAIC#25623) General Policy No. 123740-SK."

52. On January 26, 2010, David Nellson, as "secretary" of "Grand Resources Capital Solutions," wrote a letter to Oceanic Indemnity, stating: "Please take this letter as confirmation that we accept the Reinsurance Treaty, #123740-SK, and acknowledge that this treaty is limited (under the limitation act) to the exposure adopted by United States

Contractors Trust (a Delaware Risk Retention Group) for fronting the Wilshire Holding Company, LLC risk only."

53. USCT is not licensed as a risk retention group.

54. In furtherance of the enterprise, and in an attempt to obtain reinsurance for the program, Worthy posted fake letters of credit which he provided to Oceanic Indemnity Corporation, committing bank and wire fraud.

55. Sometime in March 2010, Worthy and Clark led Dunn to believe that USCT was a risk retention group and was the managing general underwriter for Phoenix. By this time, Dunn had begun to receive queries from several state regulators, and he began to badger Clark for proof that the insurance defendants were selling to Dunn's CEO Clubs association, to various other associations, and to members of the general public was real.

56. Worthy, in an attempt to obstruct justice, and knowing that Dunn would relay whatever Worthy sent to him to State regulators, provided Dunn by email with a policy number 123742-SK (the number of the "Phoenix" policy allegedly issued to CEO Clubs and its affiliated associations was 123740-SK, and the telephone number on each of the two policies was identical), effective November 1, 1009, issued by Star Group UK/Phoenix International Group. The policy was signed by "David Nellson, Senior Trustee."

57. On March 12, 2009 Worthy, in a further attempt to obstruct justice, assured Dunn in an e-mail that Phoenix was still the carrier for Dunn's associations and that USCT was licensed to write insurance in 40 states. Those statements, which Worthy

intended Dunn to rely upon, were false, constituted wire fraud, and as Worthy knew that his email would be sent to State regulators, also constituted obstruction of justice.

58. On March 16, 2010, Nellson, as "senior trustee" of USCT, sent a letter to Wilshire Holding Corporation, addressed to Worthy, asking for a "no claims" certification from the TPA so that the Wilshire-USCT-Oceanic Indemnity deal could move forward.

59. On March 20, 2010, Clark sent an e-mail to Dunn, with a copy to Worthy, stating:

> I am very pleased to report that our principal's [sic] have made arrangements for a new carrier, better suited to our market, to replace Phoenix effective 1.1.09. There is a meeting scheduled for Monday with all the parties involved to work out the legal arrangements for this book transfer. I anticipate being able to provide each of you with documentation of this new arrangement by mid-week. In the meantime, I can report that all of the respective DOI offices have been contacted and made aware of this development. It has been confirmed that Phoenix is on, and has been on, the risk since 1.1.09 and will remain so until this transfer is completed…

60. Clark's statement that "all the respective DOI offices have been contacted and are aware" was false and also constituted wire fraud.

61. On March 22, 2010, David L. Nellson sent a letter to Clark on USCT letterhead:

> It seems that there is some misunderstanding in the marketplace of the relationships between the United States Contractors Trust, a Risk Purchasing Group, the Phoenix Insurance Company, and your marketing organization. The purpose of this letter is to document this relationship. The contractual relationship between the Star Group and United States Contractors Trust confirms that the liability coverage issued by Star Group, intitiated by their senior underwriter, issued under their binding authority, is binding for Phoenix International Ltd., a subsidiary of the Phoenix Insurance Ltd., which is the ceding company and therefore carries the final risk. Phoenix International Ltd. is fully owned by the Phoenix Insurance Company, CT, and their operational office in Dallas, Texas. Phoenix International Ltd. covers liability under the NAIC registration of their owner. Should there be any issues in regards to this

relationship, you may use this letter as support of your efforts in distributing this program through your marketing network.

62. Nelson's letter was false, and constituted an act of Mail Fraud.

63. Throughout the entire period of December 2009 through March 10, 2010, Worthy, Clark, DeLuca, Karns and Katz, individually and through their companies and through their agents, processed more than 4,000 separate premium payments, knowing that a valid policy of insurance did not exist.

64. Katz also sold memberships in associations, and fraudulent insurance policies to unsuspecting individuals. Among the individuals defrauded by defendant Katz, to whom he sold nonexistent insurance policies, and/or whose dues he stole, include Sondra Weserman (Jacksonville, Florida); Robert Snowden (Meridian, Mississippi); James Rosenberg (Studio City, California); Patricia Parnell (Garland, Texas); Ina Marie Maddox (Nashville, Tennessee); Ray D. Jack (Strasburg, Virginia); Barbara Henderson (Kennesaw, Georgia); and Emily Haas (Lenhartsville, Pennsylvania). In each case, Katz forwarded counterfeit membership ID cards and counterfeit insurance cards through the mail, and/or collected and stole premium dollars. Katz directed people to the www.accesshealth.com website which falsely advised of the availability of "insurance" through the non-existent insurance program. Katz intended that people would rely on this information on the website and pay "premium" dollars in response thereto.

65. In March 2010, and on several occasions thereafter, various associations and/or consumer groups affected by their fraudulent sales of insurance sent cease and desist letters to Worthy, Clark, DeLuca, Karns and Katz demanding that they stop, inter alia, collecting premiums for non-existent insurance policies. Upon information and

belief, Worthy, Clark, DeLuca, Karns and Katz and their agents - despite receiving cease and desist letters - continued to collect premiums for their fraudulent "insurance" policies, both in the form of direct payments for same, and by taking deductions from dues of various associations and, upon information and belief, they continue to do so.

66. Upon information and belief, after receiving the cease and desist letters from various associations and/or consumer groups, Clark, DeLuca, Karns and Katz continued converting both premium dollars and membership dues from individuals who thought that they were joining one or more associations through them, and who thought they were also actually obtaining medical and/or health insurance, wholly or in part through the payment of these dues.

67. As of the drafting of this Complaint, it appears from postings on the Internet that some or all of the defendants are continuing their association-in-fact enterprise by soliciting non-existent insurance policies through the Internet to members of the public, members of some or all of the associations with which they have become affiliated, and leading those with outstanding claims for medical insurance coverage to continue to believe that those claims might actually be paid. At least as of September 1, 2010, defendant Clark was still falsely advertising on the Internet various insurance policies and programs allegedly "insured" through defendant U.S.C.T.

CLASS ACTION ALLEGATIONS

68. Plaintiff brings this action individually and as a class action on behalf of all persons and entities who, from January of 2001 to the present (the "Class Period"), purchased interests in one or more of defendants' fraudulent insurance policies.

Excluded from the class are the defendants herein, any person, firm, trust, corporation, officer, director or other individual in which any of the defendants has a controlling interest or which is related to or affiliated with any of the defendants, and the legal representatives, heirs, successors-in-interest or assigns of such excluded parties.

69. Upon information and belief, the defendants sold or issued in excess of $15 million of their fraudulent "insurance" products during the Class Period, to thousands of class members, located in New Jersey, and numerous other states. Therefore, the members of the Class are so numerous that joinder of all members is impracticable. While the exact number of class members is unknown to plaintiff at this time and can only be ascertained through appropriate discovery, plaintiff believes that the entire Class includes in excess of 20,000 persons. It is impractical to bring all members of the class before this Court.

70. The claims of plaintiff are typical of the claims of the members of the Class, as plaintiff and all members of the plaintiff Class sustained damages arising out of defendants' wrongful conduct complained of herein.

71. Plaintiff will fairly and adequately protect the interests of the members of the Class, and she has retained counsel competent and experienced in class action litigation.

72. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members is impracticable. Furthermore, the expense and burden of individual litigation makes it impossible for the class members to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

73. Common questions of law and fact exist as to all members of the Class and predominate over any questions affecting solely individual members of the Class. Among the questions of law and fact common to the Class are:

(a) Whether defendants violated the federal RICO statute, by engaging in a pattern of fraud in connection with the sale of fraudulent medical insurance "policies," and related fraudulent health insurance products;

(b) Whether the defendants committed common law fraud, intentional or reckless misrepresentations, and/or negligence by directly or indirectly participating in the acts alleged herein;

(c) Whether documents and statements publicly disseminated by defendants relating to their fraudulent "insurance" policies contained materially false and misleading statements and representations, and/or omitted to state material facts necessary to make the statements made not false and misleading.

(d) Whether defendants acted willfully, recklessly or negligently in disseminating materially false or misleading information, or omitting to state and/or in misrepresenting material facts, in connection with the sale of their fraudulent insurance "policies"; and

(e) Whether plaintiff, and the members of the plaintiff Class have sustained damages by reason of the defendants' misrepresentations and omissions, and the pattern of fraudulent behavior complained of herein and, if so, the proper measure of such damages.

FIRST CLAIM
(Racketeer Influenced and Corrupt Organizations Act)

74. Plaintiff repeats the allegations of paragraphs 1 through 73 of this Complaint, and makes them a part hereof as if more fully set forth herein.

75. The plaintiff is a "person" within the meaning of l8 U.S.C. § l96l(3) and l8 U.S.C. §l964(c), and brings this action pursuant to l8 U.S.C. §l964(c).

76. Each of the defendants named in this Count, hereinafter sometimes collectively referred to as the "RICO defendants," is a "person" within the meaning of 18 U.S.C. §1961(3). These defendants are: defendants Worthy, Clark, RBA, IRG, DeLuca, Karns, IIM, USCT, Katz, Nellson, and Viking. The RICO defendants have engaged in a pattern of racketeering activity, over a period of approximately ten years, which involved, inter alia, the fraudulent sale of medical and/or health insurance products, by repeatedly effectuating the sale of those insurance products to plaintiff, and thousands of other individuals, with the false promise that the said products represented valid and legitimate medical and/or health insurance coverage, knowing full well that this promise was false, and that the so-called "insurance" they were selling, was actually nonexistent; and by conducting the affairs of an enterprise, which they were either employed by or associated with, either singularly or collectively, through a pattern of racketeering activity within the meaning of 18 U.S.C. §1961(1) and (5), as more particularly described below. Given the length and duration of the pattern of racketeering activity engaged in, and the ease with which this same pattern could be continued through other corporate enterprises which, like the enterprises described below, are completely separate and apart from this pattern of racketeering activity, there is every likelihood that these same individual and corporate defendants will continue to engage in this same pattern of fraudulent behavior. Thus, the

threat of the continuation of the pattern of racketeering activity complained of herein is both real and substantial.

77. The RICO defendants utilized virtually identical insurance "policies," and standardized oral misrepresentations to effectuate their fraudulent "insurance" sales, over the period of years referred to herein, and engaged in other activities and courses of conduct which were repetitive, and related both directly and indirectly to this same pattern of fraudulent activity.

78. Each enterprise described in this Complaint is an "enterprise" within the meaning of l8 U.S.C. §l96l(4). During the relevant times as described above in this Complaint, each enterprise as described herein engaged in, or its activities affected, interstate and/or foreign commerce.

79. Each of the corporate defendants referred to herein is an enterprise within the meaning of l8 U.S.C. §l96l(4). In addition, USCT is an enterprise, within the meaning of l8 U.S.C. §l96l(4), through which the pattern of fraudulent activity complained of herein was carried out.

80. Alternatively, or in addition to the enterprise(s) set forth above, the RICO defendants were a group associated-in-fact that constituted an enterprise within the meaning of l8 U.S.C. §l96l(4). The "enterprise" has a purpose and structure distinct from that inherent in the conduct of defendants' pattern of racketeering in that the enterprise's business is to sell health insurance.

81. During the relevant times, the RICO defendants were employed by or associated with the said enterprise(s) (hereinafter the "enterprise").

82. During the relevant times, within the meaning of 18 U.S.C §1962(c), the RICO defendants conducted and participated, directly and indirectly, in the racketeering activity complained of herein.

83. The said racketeering activity consisted of two or more incidents of racketeering conduct engaged in by the RICO defendants, either pursuant to l8 U.S.C. §2, or under principles of respondeat superior or agency; said activity being part of the defendants' regular way of doing business.

84. As noted, the said racketeering activity emanated from a scheme to defraud the plaintiff whereby the RICO defendants, through false and fraudulent pretenses, representations, and promises, unlawfully induced plaintiff to purchase their fraudulent "insurance" policies, pursuant to a false promise of the prospect for real insurance coverage, based upon the misrepresentations and omissions referred to herein; and unlawfully induced plaintiff, and the plaintiff class to consent to the purchase of the said policies, knowing all along that the said "insurance" was nonexistent.

85. The racketeering activity, as described in l8 U.S.C. §l96l(1), includes but is not limited to:

(a) One or more instances of mail fraud within the meaning of l8 U.S.C. §l96l(1) and l8 U.S.C. §l34l;

(b) One or more instances of wire fraud within the meaning of l8 U.S.C. §l96l(1)(B) and l8 U.S.C. §l343; and

(c) One or more instances of transporting in interstate commerce goods, wares, merchandise, securities or money of the value of $5,000 or more, converted or taken by fraud or causing persons to travel in interstate commerce in the execution and concealment

of a scheme or artifice to defraud within the meaning of l8 U.S.C. §l96l(1)(B) and l8 U.S.C. §23l5;

86. The instances of mail fraud referred to in Paragraph 85 of this Claim, and which constitute violations of l8 U.S.C. §134l, are acts whereby the defendants, with purpose of executing or attempting to execute the unlawful acts described above, repeatedly caused letters and other matters and things to be delivered through the United States Postal Service, as detailed in the allegations set forth above. Examples include mailings of written policies, solicitation materials, and bills to prospective purchasers, and to a national network of insurance brokers.

87. The one or more instances of wire fraud referred to in Paragraph 85 above, and which constitute violations of l8 U.S.C. §1343, are acts whereby the defendants transmitted or caused to be transmitted by means of wire communications in interstate or foreign commerce, writings, signs, signals, pictures of sounds for the purpose of executing a scheme or artifice to defraud the plaintiff, or for obtaining money or property of the plaintiff by means of false or fraudulent pretenses, representations or promises as set forth in this Complaint and as in the allegations set forth above. Examples include interstate telephone calls by the RICO defendants to prospective purchasers, and to insurance brokers, seeking to promote sales of their fraudulent insurance policies.

88. The instances of transporting in interstate commerce goods, wares, merchandise, securities or money, of a value of $5,000 or more, converted or taken by fraud or causing persons to travel in interstate commerce in the execution and concealment of the scheme of or artifice to defraud, referred to in Paragraph 85 above, and which constitute violations of l8 U.S.C. §2314, include, but are not limited to the circulation of false and

fraudulent information to the news media, insurance brokers, and prospective purchasers, and the transportation of millions of dollars in investment funds in interstate commerce, to effectuate the fraudulent sale of insurance policies.

89. The plaintiff was directly injured by the defendants in her business and property in an undetermined amount, by reason of defendants' violations of l8 U.S.C. §l962(c) as described herein, and within the meaning of l8 U.S.C. § l964(c).

90. Each of the defendants also violated 18 U.S.C. § 1962(d) by knowingly and willingly participating in a conspiracy to defraud plaintiff, and the plaintiff class.

91. As a result of such defendants' violations of 18 U.S.C. §§ 1962(c) and (d), plaintiff has been financially injured by the amount of her premium payments to defendants, plus the value of insurance claims uncovered and unpaid by reason of defendants' fraudulent scheme, and consequential damages. Plaintiff and the plaintiff class are further entitled to recover treble damages and attorneys fees, pursuant to the federal RICO statute.

WHEREFORE, Plaintiff prays for the relief as hereinafter set forth.

SECOND CLAIM
(Fraud and Deceit)

92. Plaintiff realleges and specifically incorporates herein by reference the allegations contained in Paragraphs 1 through 91 set forth above.

93. Plaintiff asserts this Claim against all defendants, for activities they engaged in during all relevant time periods referred to herein.

94. Beginning in or about 2001, defendants commenced a common scheme, plan and conspiracy that continues to date. The primary purpose and effect of the defendants'

conspiracy and scheme was to fraudulently obtain money or property of the plaintiff by means of false or fraudulent pretenses, representations or promises as set forth in this Complaint and as in the allegations set forth above, to induce plaintiff to purchase nonexistent medical and/or health "insurance" policies, all for the purpose of generating huge and substantial profits for the defendants themselves, at the cost and expense of the plaintiff and the plaintiff class. Defendants, and each of them, actively participated in and/or aided and abetted acts in furtherance of this conspiracy including, among other things, inducing various associations, consumer groups, and insurance brokers to breach their fiduciary duties to plaintiff, and using the corporate defendants as vehicles for disseminating false and misleading statements to plaintiff and the plaintiff class in the purchase of medical insurance, and/or health insurance.

95. These defendants, individually and in concert, directly and indirectly engaged in, and aided and abetted a common plan, scheme, and continuing course of conduct and conspiracy. In so doing, defendants knowingly engaged in acts and transactions to misrepresent and/or omit material facts, as set forth above, which operated as a fraud and deceit upon the plaintiff, and the plaintiff class.

96. The materially false and misleading statements and omissions made to plaintiff and the plaintiff class at the time of their purchase of their insurance "policies," were made by defendants, and each of them, with an intent to deceive or defraud plaintiff, and the plaintiff class or to aid and abet the deception and defrauding of them. The purpose and effect of defendants' scheme and conspiracy to defraud was to induce plaintiff and the plaintiff class to purchase phony "insurance" policies, and then to induce plaintiff and the plaintiff class to make payments of premiums toward the purchase of nonexistent medical

and/or health insurance coverage, so that defendants could earn substantial profits by reason of such sale, at the cost and expense of plaintiff and the plaintiff class. Said acts by defendants were fraudulent, oppressive, deceitful, and malicious.

97. Plaintiff and the plaintiff class, at the time of said misrepresentations and omissions, were necessarily ignorant of these omissions and misrepresentations of material facts, which they believed to be true. In reliance upon the superior knowledge of the defendants, plaintiff and the plaintiff class purchased the defendants phony "insurance" policies, pursuant to a false promise of the opportunity for medical and/or health insurance coverage at reasonable rates. If plaintiff and the plaintiff class had known the true facts, they would never have purchased defendants' "insurance" policies to begin with. By reason thereof, plaintiff and the plaintiff class have suffered, and will continue to suffer, substantial damages.

98. Defendants had a duty to fully disclose to plaintiff, all material facts concerning the "insurance" policies sold, and/or to be sold by them.

WHEREFORE, Plaintiff prays for the relief as hereinafter set forth.

THIRD CLAIM
(Breach of Fiduciary Duties)

99. Plaintiff realleges and specifically incorporates herein by reference the allegations contained in Paragraphs 1 through 98 of this Complaint.

100. Defendants had a fiduciary duty to act in the best interests of the plaintiff and the plaintiff class, in connection with the sale to them of all "insurance" policies under their supervision and control. A special relationship of trust and confidence existed between plaintiff, the plaintiff class, and these defendants, reposing in defendants the obligations of

that of a trustee acting on behalf of plaintiff and the plaintiff class, in all matters relating to the relationship.

101. Defendants breached their fiduciary duties to the plaintiff and the plaintiff class by working instead to consummate the sale to them of "insurance" policies they knew to be either nonexistent and/or devoid of value, despite their knowledge that these transactions would most likely fail to maximize the value of the premium payments of plaintiff and the plaintiff class, and fail to protect them from the risks of liability for substantial medical expenses, by reason of their lack of coverage for those expenses, and/or defendants' inability or unwillingness to administer the said policies in a manner designed to provide plaintiffs with meaningful value in return for their "insurance" coverage.

102. Through the foregoing acts, practices and course of conduct, these defendants were grossly negligent in failing to use special care and diligence in the exercise of their fiduciary obligations to the plaintiff and the plaintiff class, and have therefore violated, and continue to violate, their fiduciary duty of care to the plaintiff and the plaintiff class.

103. The acts of defendants complained of herein were and are in breach of their fiduciary duty of loyalty to plaintiff, in that these defendants knew that their actions involved improper self-dealing and other acts in derogation of the fiduciary duties owed by them, as issuers of medical and/or health insurance to plaintiff and the plaintiff class.

104. As a proximate cause of defendants' conduct noted above, plaintiff and the plaintiff class have been damaged and are entitled to recover an amount which will compensate them for all the detriment proximately caused thereby, whether it could have been anticipated or not.

105. The conduct of these defendants was undertaken fraudulently, maliciously, willfully and in reckless disregard of the rights of plaintiff, and was intended and directed to harm the plaintiff and the plaintiff class, and to advance the personal interests of these defendants, entitling plaintiff and the plaintiff class to an award of punitive damages.

WHEREFORE, Plaintiff prays for the relief as hereinafter set forth.

FOURTH CLAIM
(Negligent Misrepresentation)

106. Plaintiff realleges and specifically incorporate herein by reference the allegations contained in Paragraphs 1 through 105 of this Complaint.

107. This claim is asserted against all defendants, for negligent misrepresentation and negligence.

108. Each of the defendants made misrepresentations of material facts, and omitted to make material disclosures to plaintiff through the preparation, publication and dissemination of the Solicitation Materials utilized to effectuate the sale of medical and/or health insurance policies to plaintiff and the plaintiff class.

109. In making said omissions and representations, as well as those described throughout this Complaint, all defendants omitted to state material facts necessary to make the statements made, in light of the circumstances under which they were made, not misleading, and made misrepresentations of material fact. Among the direct and proximate causes of said misrepresentations and omissions was the negligence and carelessness of these defendants.

110. At the time of said misrepresentations and omissions, plaintiff and the plaintiff class were ignorant of their falsity and believed them to be true. In reasonable and

foreseeable reliance upon said misrepresentations, and in reliance upon the superior knowledge and expertise of these defendants, and in ignorance of the true facts, the plaintiffs and the plaintiff class were induced to purchase defendants' nonexistent and/or valueless "insurance" policies. Had plaintiff and the plaintiff class known the true facts, they would not have taken such action.

111. As a result of such negligence, all members of the plaintiff class have suffered and will continue to suffer damages.

WHEREFORE, Plaintiff prays for the relief as hereinafter set forth.

FIFTH CLAIM
(For Imposition of Constructive Trust)

112. Plaintiff and the plaintiff class incorporate by reference paragraphs 1 through 111 set forth above.

113. This Claim is asserted against all defendants, with respect to any and all of the substantial monies obtained from plaintiff by any and all defendants by virtue of fraud, breach of fiduciary duties and/or negligence in connection with their fraudulent sale of "insurance" policies to plaintiff and the plaintiff class.

114. Plaintiff and the plaintiff class reposed trust and confidence in the defendants as fiduciaries in the management of their premium payments, and the operation of the "insurance" policies. As a result of their relationship with and control over their premium payments and policies, all defendants assumed positions of trust with respect to the plaintiffs, as well as with respect to their health care providers. All proceeds paid, and/or purportedly payable to any of the defendants in connection with the sale of "insurance" policies to plaintiff and the plaintiff class, have been procured in breach of trust.

115. Plaintiff and the plaintiff class are the true, sole and equitable owners of those proceeds paid to any and all defendants in connection with the purchase of their "insurance" policies. Plaintiffs' equitable interests in those proceeds are therefore superior to all others.

116. Defendants, and each of them, participated in, and aided and abetted, the above-described violations of the federal RICO statute, and the other wrongful acts, with the express intent to obtain monies rightfully belonging to plaintiff and the plaintiff class. As a direct and proximate result of defendants' wrongful conduct and breaches of trust, defendants wrongfully acquired substantial sums of monies rightfully belonging to plaintiff and the plaintiff class, and of which defendants are now constructive trustees.

117. The defendants have no legal or equitable right or interest in any funds rightfully belonging to the plaintiff and the plaintiff class, and are constructive trustees of such funds, owing a duty to transfer same to plaintiff.

118. The defendants are, therefore, also constructive trustees of:

a. All commissions received as a result of the purchase of limited partnership interests, and/or the real property owned by the limited partnerships.

b. All management and other fees received, including those authorized, and not authorized by the original limited partnership agreements.

c. All other revenue received by the defendants, as a result of the wrongful acts complained of herein.

119. Plaintiff and the plaintiff class hereby assert their equitable interests, as described above, and demand the imposition of a constructive trust as to all proceeds so described.

PRAYER FOR RELIEF

WHEREFORE, plaintiff prays for relief against defendants and each of them, jointly, severally, or in the alternative, as follows:

A. Certifying this action to proceed as a class action, pursuant to the provisions of Rule 23(b)(3), Fed. R. Civ. P.;

B. Awarding plaintiff and the class compensatory damages, in the amount of $20,000,000, or such other amount as may be proved at trial, together with pre-judgment and post-judgment interest.

C. Awarding plaintiff and the class punitive damages, by reason of the wanton, malicious, intentional and/or reckless nature of the wrongs perpetrated against them.

D. Declaring a constructive trust upon all funds paid or payable to any and all of the defendants, in connection with the purchase of defendants' fraudulent "insurance" policies.

E. Requiring an immediate, and full accounting of all transactions consummated by any of the defendants, with respect to the insurance policies referred to herein.

E. Awarding plaintiff threefold their damages, the cost of this action, and reasonable attorneys' fees pursuant to 18 U.S.C. 1961(1) et seq.

F. Awarding plaintiff such other and further relief as this Court may deem proper and just.

DEMAND FOR JURY TRIAL

Plaintiff hereby demands trial by jury of all issues as allowed by law.

LAW OFFICES OF G. MARTIN MEYERS, P.C.
ATTORNEYS FOR PLAINTIFF AND THE CLASS

Dated: February 24, 2011

By: /s/ G. Martin Meyers
G. MARTIN MEYERS, ESQ. (5833)