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Receiver of Defendants Secure Investment Services, Inc., American Financial Services, Inc., and Lyndon Group, Inc.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
SACRAMENTO DIVISION

SECURITIES AND EXCHANGE COMMISSION, Plaintiff, v. SECURE INVESTMENT SERVICES, INC., AMERICAN FINANCIAL SERVICES, INC., LYNDON GROUP, INC., DONALD F. NEUHAUS, and KIMBERLY A. SNOWDEN, Defendants.	Case No. 2:07-cv-01724 LEW CMK RECEIVER'S SECOND MOTION TO COMPEL ERNEST JEREMIAS TO EXECUTE REINSTATEMENT FORMS Date: June 22, 2009 Time: 9:00 a.m. Department: 10

TO THE HONORABLE GARLAND E. BURRELL, JR., UNITED STATES DISTRICT JUDGE:

Michael J. Quilling, the Receiver appointed in these proceedings ("Receiver"), files this Second Motion to Compel Ernest Jeremias to Execute Reinstatement Forms and in support of such would show the Court as follows:

1. By Orders dated August 24, 2007 (Dkt. No. 27) and October 30, 2007 (Dkt. No. 80), the Receiver was appointed by this Court.

2. As the Court is aware, the primary assets belonging to the receivership estate are a number of insurance policies covering the lives of third parties. Secure Investment Services, Inc. or one of its related entities (collectively, "SIS") purchased those policies and sold fractional ownership interests to investors who are now creditors of this receivership estate.

3. At the time the Receiver was appointed, the available records indicated that SIS owned a $1,000,000 insurance policy issued by William Penn Insurance Company and covering the life of Ernest Jeremias. Throughout these proceedings, the Receiver has referred to this as the JER-E(4) policy. The Receiver later determined that the JER-E(4) policy lapsed on or about May 16, 2007 due to SIS's failure to pay premiums.

4. In relevant part, the JER-E(4) policy contains the following reinstatement provision:

Reinstatement

> A policy which terminates in accordance with the grace period provision may be reinstated within five years after the expiration of the grace period if:
>
> 1. the owner submits a written application; and
> 2. evidence of your insurability is received and approved by us; and
> 3. the owner pays sufficient premium sufficient to keep this policy in force for two months; and
> 4. any policy loan is paid or reinstated.

The JER-E (4) policy terminated in accordance with the grace period and there is no policy loan. The Receiver is willing to pay the premium required to reinstate the policy. Thus, the policy could be reinstated if Ernest Jeremias would sign and complete the forms attached as Exhibit 1 so the Receiver has evidence of insurability.

5. At the beginning of this case, the Receiver retained National Viatical, Inc. ("NVI") as his agent to manage the portfolio of life insurance policies. Since that time, NVI has diligently tried to obtain reinstatement information from Mr. Jeremias without success. Mr. Jeremias first told NVI that he never applied for or sold that insurance policy. When they

presented him with evidence to the contrary, Mr. Jeremias then promised to provide the information and return his signed forms.

6. After waiting several months, the Receiver had to file a Motion to Compel Ernest Jeremias to Execute Reinstatement Forms [Dkt. No. 336]. Mr. Jeremias eventually completed all of those forms and the Receiver submitted them to William Penn Insurance Company for review. The Receiver accordingly filed a notice [Dkt. No. 423] withdrawing his motion to compel on January 27, 2009.

7. William Penn Insurance Company later determined that it also needed Mr. Jeremias to complete a personal information statement, complete a Daily Activities Questionnaire, submit to a personal examination by a medical doctor, provide blood and urine samples, and submit to an EKG. A true and correct copy of the insurance company's request is attached as Exhibit 2. Mr. Jeremias has refused and continues to refuse those requests. A true and correct copy of his written refusal is attached as Exhibit 3.

8. The insurance company has recently informed the Receiver that it will require Mr. Jeremias to begin the reinstatement process all over again, including filling out the forms attached as Exhibit 1.

9. The Receiver now asks this Court for an order compelling Ernest Jeremias to:

a. complete and execute the forms attached as Exhibit 1 and produce them to the Receiver within 14 days;

b. complete and execute the forms attached as Exhibit 2 and produce them to the Receiver within 14 days;

c. schedule and attend the physical examination and tests described in Exhibit 2 within 30 days; and

d. provide in a timely manner any other personal, medical, or financial information requested by William Penn Insurance Company as part of the reinstatement process.

10. SIS purchased a total of six insurance policies on Ernest Jeremias for which he received more than $402,500.00. He paid nothing for those policies and has profited handsomely by selling them. He should be compelled to provide the information and attend examinations requested by the insurance provider.

11. Without question, District Courts have authority to subject individuals to physical examinations. Federal Rule of Civil Procedure 35 governs this procedure:

> The court where the action is pending may order a party whose mental or physical condition . . . is in controversy to submit to a physical or mental examination by a suitably licensed or certified examiner.

FED. R. CIV. P. 35 (a)(1). Ernest Jeremias' physical condition is "in controversy" in this case because William Penn Insurance Company requires evidence of his insurability before they will honor the Receiver's right to reinstate the policy.

12. The Receiver submits that the Court may deem Mr. Jeremias to be a "party" in this action. The Supreme Court has held that Rule 35 applies to defendants in a lawsuit. Schlagenhauf v. Holder, 379 U.S. 104, 114 (U.S. 1964). But rather than bring a separate lawsuit against Mr. Jeremias, the Receiver files this motion to obtain relief against him through summary procedures. Federal receivership law recognizes the use of such procedures to resolve disputes implicating receivership assets. *SEC v. Basic Energy & Affiliated Resources,* 273 F.3d 657, 668 (6th Cir. 2001); *see also Commodity Futures Trading Comm'n v. Topworth Int'l, Ltd.,* 205 F.3d 1107, 1113 (9th Cir. 2000); *SEC v. Wencke,* 783 F.2d 829, 837-38 (9th Cir. 1986). It is well settled that Federal Courts have "broad powers and wide discretion" to fashion such relief in equitable receivership proceedings. *Basic Energy & Affiliated Resources,* 273 F.3d at 668. This

discretion, which derives from the Court's inherent equitable powers, makes abbreviated and summary proceedings possible without violating the interests of due process. *See id.* (allowing summary proceedings so long as they "permit parties to present evidence when the facts are in dispute and to make arguments regarding those facts"); *SEC. v. Elliott*, 953 F.2d 1560, 1571 (9th Cir. 1992). Therefore, as long as this Court gives him a meaningful opportunity to present his factual and legal contentions, summary proceedings are proper to determine whether Mr. Jeremias must submit to William Penn Insurance Company's reinstatement procedures.

13. Clearly it is in the receivership estate's best interest to keep this life insurance policy from permanently lapsing. If it is not reinstated, the estate will suffer tremendous harm by losing the entire ownership interest in a $1,000,000 life insurance policy. The lost value to the estate is even worse when one considers the amount that SIS spent to purchase that policy and pay premiums for it. Fortunately, this can be avoided. The Court can compel Mr. Jeremias to comply with the reinstatement procedures, which are all standard industry practices. Courts overseeing federal receiverships have broad powers and discretion to achieve equitable results. *SEC v. Lincoln Thrift Ass'n*, 577 F.2d 600, 606 (9th Cir. 1978). This Court should compel Mr. Jeremias to submit to the procedures for reinstatement just like he did when he originally obtained and sold this policy.

WHEREFORE, premises considered, the Receiver prays that upon final hearing and consideration of this matter that the Court enter an order consistent with the foregoing and for such other and further relief, general or special, at law or in equity, to which the Receiver has shown itself justly entitled.

Respectfully submitted this 21st day of May, 2009.

Respectfully submitted,

/s/ Michael J. Quilling
MICHAEL J. QUILLING (Tex. Bar No. 16432300)
BRENT J. RODINE (Tex. Bar No. 24048770)

QUILLING, SELANDER, CUMMISKEY & LOWNDS, P.C.

Chris Gibson, SBN 073353
Maralee MacDonald, SBN 208699
BOUTIN GIBSON DI GIUSTO HODELL INC.

Attorneys for Receiver

CERTIFICATE OF CERTIFIED MAIL SERVICE

I hereby certify that on the 21st day of May, 2009, a copy of this Motion was served on all interested parties through the Court's electronic filing system. In addition, a copy of this motion was served on by U.S. Certified Mail, Return Receipt Requested on the following person at his last known address:

Ernest Jeremias
5022 17th Avenue, Apt. 1
Brooklyn, NY 11204

/s/ Michael J. Quilling
Michael J. Quilling

CERTIFICATE OF SERVICE

I hereby certify that on the 21st day of May, 2009, a copy of this Motion was served on all interested parties through the Court's electronic filing system. In addition, a copy of this motion was served on the following other persons by First Class U.S. Mail:

Bazzle John Wilson
1291 Nunneley Road
Paradise, CA 95969

/s/ Maralee MacDonald
Maralee MacDonald

Exhibit "1"

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
100 QUENTIN ROOSEVELT BOULEVARD • PO BOX 519 • GARDEN CITY, NEW YORK 11530

APPLICATION FOR REINSTATEMENT

This application must be completed in its entirety and properly signed. Each insured covered by the policy is to complete an Application for Reinstatement, answering each of the following questions. Explain any "yes" answers on page 2 of this form. Please print.

Policy No. _____

Name of Insured _____ Phone Number _____

Address _____

Name of Policy Owner _____ Phone Number _____
(if other than Named Insured)

Address _____

Please provide the name, address and phone number of your personal physician: _____

Please answer the following questions and provide details for all "yes" answers in the Additional Information section on page 2. Complete details will allow us to evaluate your request for reinstatement without delay.

Since the issue date of the policy, has this insured:

		Yes	No
1. a.	Consulted or been treated by any physician or other licensed medical practitioner?	☐	☐
b.	Had any physical impairment, sickness, operation, mental illness/disorder, physical injury?	☐	☐
c.	Taken or been advised to take any prescription or non-prescription medication? If yes, name medication, dosage, prescribing physician in Additional Information.	☐	☐
2. a.	Had a change in weight in the past 12 months? If yes: lbs. lost_____ lbs. gained_____ reason_____	☐	☐
b.	Provide current: height _____ weight _____		
3.	Been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
4.	Ever used cigarettes, cigars or any other form of nicotine-based products?	☐	☐
	If yes: do you currently smoke or use other form of nicotine-based products?	☐	☐
	What product do you use and how frequently_____		
	If not currently smoking or using a nicotine-based product, provide date last used: _____		
5. a.	Used barbiturates, heroin, cocaine (including crack), marijuana, or any other illegal, restricted, or controlled substance except as prescribed by a physician, or been advised by a physician or other medical practitioner to seek or receive treatment for drug use? If yes, provide full and complete details.	☐	☐
b.	Been convicted for drug use, possession or distribution? If yes, provide full and complete details.	☐	☐
6. a.	Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐
b.	Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?	☐	☐
c.	Attended or joined any organization for alcohol or related problems?	☐	☐
7.	Had an immediate family member (parent, brother or sister) with heart disease, stroke, diabetes, cancer, polycystic kidney disease or other familial disease? If yes, identify relationship, disease, age at diagnosis, current age or age at death.	☐	☐

	Yes	No
8. Been convicted of a felony or misdemeanor? ..... If yes, provide full and complete details including date and charge/reason.	☐	☐
9. a. Had a driver's license restricted, revoked or suspended? ..... If yes, provide full and complete details including date and reason.	☐	☐
b. Been convicted of DWI/DUI? ..... If yes, provide full and complete details including date and charge/reason.	☐	☐
c. Driver's License State and No. _____		
10. Engaged or intend to engage in hang gliding, hot air ballooning, racing, mountain/rock climbing, skin, scuba or sky diving? ..... If yes, provide full and complete details.	☐	☐
11. Flown in the last five years or intend to fly other than as a fare paying passenger on scheduled airlines? ..... If yes, provide full and complete details.	☐	☐
12. Do you intend to travel or reside outside the continental United States within the next five years? ..... If yes, provide dates, location, purpose of travel, frequency and intended length of stay.	☐	☐
13. Applied to any other company for new insurance or reinstatement of lapsed coverage? ..... If yes, provide type, company, amount and status, including reason if refused or rated.	☐	☐
14. What is your total amount of life insurance currently in force, excluding this lapsed policy? _____		
15. Filed for bankruptcy? ..... If yes, provide past or future date of discharge _____	☐	☐

ADDITIONAL INFORMATION

Details regarding any "yes" answers. For questions 1, 3, 5, 6 and 7, indicate the medical condition, date of onset and recovery, name/address of physician, clinic or hospital. If children are covered, list names of children born or adopted since date policy was issued.

Question No.	Details

AUTHORIZATION

A photocopy of this authorization shall be as valid as the original, which shall be valid for 24 months. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health, to give William Penn Life Insurance Company of New York or its reinsurers any such information. This includes data related to drugs, alcoholism or mental illness. It also includes data obtained in connection with the preparation of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application. This information does not apply to records protected under 42 USC 290dd-2. To expedite the collection of data, I authorize all such sources, except the Medical Information Bureau, to give the data to any agency employed by William Penn Life Insurance Company of New York to collect and transmit such data. I further authorize William Penn Life Insurance Company of New York to prepare or obtain any investigative consumer report in connection with this application; if a consumer report is prepared, I elect to be interviewed: ☐ Yes ☐ No. I am aware that I am entitled to receive a copy of this authorization form.

NOTICE REGARDING FEDERAL FAIR CREDIT REPORTING ACT

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) DISCLOSURE

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired.)

I hereby declare that the statements and answers contained on this Application for Reinstatement and any supplements thereto, are true to the best of my knowledge and belief and are made to induce the Company to reinstate the above numbered policy. I agree that the reinstatement of coverage applied for shall in no event become effective unless this application is approved by the Company and the full amount of premium due is paid while the insured is actually in the state of health and insurability represented in this Application for Reinstatement and any supplements thereto. I agree to notify the Company of any changes in my statements or answers while the application for reinstatement is pending. I further agree that this Application for Reinstatement and any supplements thereto, copies of which shall be attached to and made part of the policy, shall be contestable at any time within two years from the effective date of the reinstatement.

Signed at_____ this_____ day of_____, 20_____.

Owner _____ Insured _____

Second Insured (if Joint Policy)_____ Witness (not a beneficiary) _____

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
100 QUENTIN ROOSEVELT BOULEVARD • PO BOX 519 • GARDEN CITY, NEW YORK 11530

RELEASE OF HEALTH-RELATED INFORMATION

Although the application you completed includes a disclosure authorization, as a result of recent changes in the federal **Health Insurance Portability and Accountability Act (HIPAA)**, your medical provider may ask for this HIPAA specific form.

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured / Patient

Date of Birth ___/___/___

Print Name of Person or Organization Providing Information

AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, treatment facility, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information concerning me for the past 10 years to **William Penn Life Insurance Company of New York**, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

This protected health information is to be disclosed under this authorization so that **William Penn Life Insurance Company of New York** may: 1) underwrite my application for coverage, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with **William Penn Life Insurance Company of New York.**

By signing below, I terminate any agreements I have made to restrict my protected health information and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 100 Quentin Roosevelt Boulevard, Garden City, NY 11530, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I understand and acknowledge that I will receive or have received a copy of this authorization.

Signature of Proposed Insured / Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned insured (hereafter referred to as "I", "me" or "Insured"), authorizes the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as follows:

1. I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, an "Authorized Discloser") to provide National Viatical, Inc. and/or its authorized representatives with any and all information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric conditions, drug or alcohol abuse, of or related to me.

2. This authorization allows for the disclosure, inspection, and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatments or hospitalization, including, but not limited to, all testing materials completed by or administered to me, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control. This authorization shall apply to any and all of the Insured's health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

3. I understand that the information authorized for release may also include life insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that policy purchasers, their medical underwriters, contingency reinsurers, and any other entity which requires or is compelled by law to receive such protected health information to complete a life insurance sale, or in order to sell a life insurance policy (collectively, the "Authorized Recipient") will use information released or obtained pursuant to this authorization, and I hereby expressly authorize such use and disclosure. This authorization may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy or facsimile of this authorization shall be valid as the original.

4. I agree that this authorization shall remain valid for the life of the undersigned (or the last to survive of the undersigned if more than one signatory) or until the policy lapses without the possibility of reinstatement, whichever is earlier, absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under.

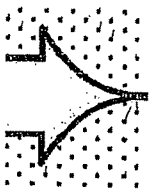
5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authored Discloser in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized Discloser; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization: No Authorized Discloser or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the HIPAA. I further understand that, as a result of this authorization, there is the potential for my protected health information that is disclosed by any Authorized Discloser to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my protected health information that is disclosed to such Authorized Recipient may no longer be protected by HIPAA.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Any person who knowlingly presents false information in connection with the sale of a life insurance policy is guilty of a crime and may be subject to fines and confinement in prison.



Authorized Disclosers:

Signature of Insured	Signature of Policy Owner
Printed Name of Insured/Date	Printed Name of Policy Owner/Date
Signature of Witness	Signature of Witness
Printed Name of Witness/Date	Printed Name of Witness/Date