AMERICAN MEDICAL SECURITY GROUP INC
Form 10-Q
November 04, 2004

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

[X] Quarterly Report Pursuant To Section 13 Or 15(d) Of The Securities Exchange Act Of 1934
FOR THE QUARTERLY PERIOD ENDED SEPTEMBER 30, 2004
OR
[ ] Transition Report Pursuant To Section 13 Or 15(d) Of The Securities Exchange Act Of 1934
For the transition period from _____ to _____

COMMISSION FILE NUMBER 1-13154

AMERICAN MEDICAL SECURITY GROUP, INC.
(Exact name of Registrant as specified in its charter)

WISCONSIN	39-1431799
(State of Incorporation)	(I.R.S. Employer Identification No.)
3100 AMS BOULEVARD GREEN BAY, WISCONSIN	54313
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (920) 661-1111

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 is an accelerated filer (as defined in Rule 12b-2 of the Exchange Act).

Yes __X__ No _____

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

Common stock, no par value, outstanding as of October 31, 2004:
13,683,383 shares

AMERICAN MEDICAL SECURITY GROUP, INC.

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PART I FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(THOUSANDS, EXCEPT SHARE DATA)	September 30, 2004
	(Unaudited)
ASSETS	
Investments:	
Fixed maturity securities available for sale, at fair value	$ 302,119

Fixed maturity securities held to maturity, at amortized cost	3,164
Trading securities, at fair value	1,797
Total investments	307,080
Cash and cash equivalents	20,756
Property and equipment, net	39,922
Goodwill	32,138
Other intangibles, net	1,468
Other assets	39,323
Total assets	$ 440,687
LIABILITIES AND SHAREHOLDERS' EQUITY	
Liabilities:	
Medical and other benefits payable	$ 106,274
Advance premiums	15,350
Payables and accrued expenses	23,846
Notes payable	30,158
Other liabilities	21,838
Total liabilities	197,466
Shareholders' equity:	
Common stock (no par value, $1 stated value, 50,000,000 shares authorized, 16,654,315 issued and 13,683,383 outstanding at September 30, 2004, 16,654,315 issued and 13,511,183 outstanding at December 31, 2003)	16,654
Paid-in capital	195,610
Retained earnings	56,164
Accumulated other comprehensive income (net of taxes of $2,795 at September 30, 2004 and $3,302 at December 31, 2003)	5,190
Treasury stock (2,970,932 shares at September 30, 2004 and 3,143,132 shares at December 31, 2003, at cost)	(30,397)
Total shareholders' equity	243,221
Total liabilities and shareholders' equity	$ 440,687

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS (Unaudited)

	Three Months Ended September 30,		Nine Se
(THOUSANDS, EXCEPT PER COMMON SHARE DATA)	2004	2003	2004

REVENUES			
Insurance premiums	$ 175,789	$ 176,735	$ 530,
Net investment income	3,506	3,211	10,
Net realized investment gains (losses)	28	1,416	
Other revenue	4,076	3,899	12,
Total revenues	183,399	185,261	552,
EXPENSES			
Medical and other benefits	117,598	119,218	348,
Selling, general and administrative	55,539	52,873	164,
Interest	255	309	
Amortization of intangibles	163	238	
Total expenses	173,555	172,638	513,
Income from continuing operations, before income tax expense	9,844	12,623	39,
Income tax expense	4,593	4,735	15,
Income from continuing operations	5,251	7,888	23,
Income from discontinued operations	-	923	
Net income	$ 5,251	$ 8,811	$ 23,
Earnings per common share - basic:			
Income from continuing operations	$ 0.38	$ 0.59	$ 1
Income from discontinued operations	-	0.07	
Net income	$ 0.38	$ 0.66	$ 1
Earnings per common share - diluted:			
Income from continuing operations	$ 0.36	$ 0.55	$ 1
Income from discontinued operations	-	0.06	
Net income	$ 0.36	$ 0.61	$ 1

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS (Unaudited)

(THOUSANDS)	Nine Mo Septe 2004
OPERATING ACTIVITIES	
Net income	$ 23,996
Adjustments to reconcile net income to net cash provided by operating activities:	
Depreciation and amortization	6,372
Net gain from sale of subsidiary	-
Net realized investment losses (gains)	24
Change in trading securities	(373)
Deferred income tax expense	6,455
Changes in operating accounts:	
Other assets	3,010
Medical and other benefits payable	(23,535)
Advance premiums	(515)
Payables and accrued expenses	(253)
Other liabilities	(3,663)
Net cash provided by operating activities	11,518
INVESTING ACTIVITIES	
Proceeds from sale of subsidiary	-
Purchases of available for sale securities	(75,593)
Proceeds from sale of available for sale securities	63,162
Proceeds from maturity of available for sale securities	9,705
Proceeds from maturity of held to maturity securities	200
Purchases of property and equipment	(6,937)
Proceeds from sale of property and equipment	3
Net cash used in investing activities	(9,460)
FINANCING ACTIVITIES	
Issuance of common stock	1,409
Purchase of treasury stock	-
Repayment of notes payable	-
Net cash provided by financing activities	1,409
Cash and cash equivalents:	
Net change	3,467
Balance at beginning of year	17,289
Balance at end of period	$ 20,756

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Unaudited)

SEPTEMBER 30, 2004

1. BASIS OF PRESENTATION

The accompanying unaudited condensed consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and footnotes required by accounting principles generally accepted in the United States ("GAAP") for complete financial statements. In the opinion of management, all adjustments (consisting of normal recurring adjustments) considered necessary for a fair presentation have been included. Operating results for the three and nine months ended September 30, 2004 are not necessarily indicative of the results that may be expected for the year ending December 31, 2004. These condensed consolidated financial statements should be read in conjunction with the consolidated financial statements and footnotes thereto included in the American Medical Security Group, Inc. (the "Company") Annual Report on Form 10-K for the year ended December 31, 2003.

2. STOCK-BASED COMPENSATION

The Company has stock-based compensation plans for the benefit of eligible employees and directors of the Company, which are described more fully in Note 11 in the Company's 2003 Annual Report on Form 10-K. During the first quarter of 2004, the Company granted 20,700 shares of restricted stock to outside members of the Company's Board of Directors. As a result, the Company's statements of operations for the three and nine months ended September 30, 2004 include compensation expense of $24,000 and $72,000 respectively, net of tax.

The Company follows Accounting Principles Board Opinion No. 25, the intrinsic value method of accounting for stock-based compensation, under which no compensation expense is recorded when the exercise price of the Company's employee stock options equals the market price of the underlying stock on the date of grant. The following table illustrates the pro forma net income and pro forma net income per share as if the Company had followed the fair value method of accounting for stock-based compensation under Statement of Financial Accounting Standards No. 123, ACCOUNTING FOR STOCK-BASED COMPENSATION ("Statement 123").

	Three Months Ended September 30,		Nine Se
(THOUSANDS, EXCEPT PER COMMON SHARE DATA)	2004	2003	2004
Net income, as reported	$ 5,251	$ 8,811	$ 23,
Add: Stock-based compensation expense included in reported net income, net of tax	24	-	
Deduct: Stock-based compensation expense in accordance with the fair value method of Statement 123, net of tax	(313)	(391)	(
Pro forma net income	$ 4,962	$ 8,420	$ 23,

Net income per common share, as reported:

Basic	$ 0.38	$ 0.66	$ 1
Diluted	$ 0.36	$ 0.61	$ 1
Pro forma net income per common share:			
Basic	$ 0.36	$ 0.63	$ 1
Diluted	$ 0.34	$ 0.59	$ 1

In determining compensation expense in accordance with Statement 123, the fair value of options was estimated at the date of grant using the Black-Scholes option valuation model, which is commonly used in estimating the fair value of traded options that have no vesting restrictions and are fully transferable. Option valuation models require the input of highly subjective assumptions including the expected stock price volatility and the expected life of the options. Because the Company's employee stock options have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimates, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

3. PENDING MERGER WITH PACIFICARE

On September 15, 2004, the Company entered into a definitive agreement and plan of merger with PacifiCare Health Systems, Inc. ("PacifiCare") whereby PacifiCare will acquire all of the outstanding shares of common stock of the Company through a cash merger in which the Company will become a wholly-owned subsidiary of PacifiCare. Under the terms of the merger agreement, PacifiCare will pay $32.75 in cash for each share of the Company's common stock outstanding for a total equity purchase price of approximately $500 million on a fully diluted basis. It is anticipated that the acquisition will be completed following approvals by the Company's shareholders, the Wisconsin Office of the Commissioner of Insurance and the Georgia Department of Insurance, and compliance with the Hart-Scott-Rodino Antitrust Improvement Act of 1976, as amended ("Hart-Scott-Rodino Act"), as well as other customary approvals. The Company's statements of operations for the three and nine months ended September 30, 2004 include merger-related transaction costs of approximately $2.6 million.

4. DISCONTINUED OPERATIONS

During the third quarter of 2003, the Company sold all of the outstanding common shares of its preferred provider organization network subsidiary, Accountable Health Plans of America, Inc. ("AHP"). The network contracted with more than 900 hospitals and 100,000 physicians in eight primary states: Arizona, Florida, Iowa, Nebraska, North Dakota, South Dakota, Texas and Wisconsin. Subject to the terms of the agreement, AHP will continue to provide network services to the Company at least until September 2008. At the time of the sale, AHP served approximately 13% of the Company's members. The three and nine-month periods ended September 30, 2003 as presented in the Company's statements of operations have been reclassified to exclude the results of the discontinued networking business from reported income from continuing operations.

5. PHARMACY BENEFITS MANAGER SETTLEMENT

During the first quarter of 2004, the Company reached an agreement with its former pharmacy benefits manager settling a dispute related to pricing and

prescription drug fees charged from 1995 through 2002. As a result of the settlement, the Company received a cash payment of $5.9 million, and the results for the nine months ended September 30, 2004 include a one-time gain of approximately $3.4 million or $0.23 per diluted share, net of taxes and other related expenses. The settlement provided a refund of medical and other benefit expenses, which resulted in an improvement in the Company's health segment loss ratio of 1.0% for the nine months ended September 30, 2004.

6. EARNINGS PER COMMON SHARE ("EPS")

Basic EPS is computed by dividing earnings by the weighted average number of common shares outstanding. Diluted EPS is computed by dividing earnings by the weighted average number of common shares outstanding, adjusted for the effect of dilutive stock options. The following table illustrates the computation of EPS for income from continuing operations and provides a reconciliation of the number of weighted average basic and diluted shares outstanding:

	Three Months Ended September 30,		Nine Se
(THOUSANDS, EXCEPT PER COMMON SHARE DATA)	2004	2003	2004
Numerator:			
Income from continuing operations	$ 5,251	$ 7,888	$ 23,
Denominator:			
Denominator for basic EPS	13,763	13,392	13,
Effect of dilutive employee stock options	929	948	
Denominator for diluted EPS	14,692	14,340	14,
Earnings per common share - income from continuing operations:			
Basic	$ 0.38	$ 0.59	$ 1
Diluted	$ 0.36	$ 0.55	$ 1

Certain options to purchase shares of common stock were not included in the computation of diluted earnings per common share for the three and nine months ended September 30, 2003 because the options' exercise prices were greater than the average market price of the outstanding common shares for the period and, therefore, the effect would be antidilutive.

7. COMPREHENSIVE INCOME

Under existing accounting standards, comprehensive income for the Company includes net income and unrealized gains and losses on certain investments in debt and equity securities, net of tax effects. Comprehensive income for the Company is calculated as follows:

(THOUSANDS)	Three Months Ended September 30, 2004	2003	Nine Se 2004
Net income	$ 5,251	$ 8,811	$ 23,
Unrealized gain (loss) on available for sale securities	3,096	(2,443)	(
Comprehensive income	$ 8,347	$ 6,368	$ 23,

8. CONTINGENCIES

In February 2000, a class action lawsuit was filed against the Company in the state of Florida alleging that the Company failed to follow Florida law when in 1998 it discontinued writing certain health insurance policies and offered new policies to insureds. Plaintiffs claim that the Company wrongfully terminated coverage, improperly notified insureds of conversion rights and charged improper premiums for new coverage. Plaintiffs also allege that the Company's renewal rating methodology violated Florida law. In 2002, a Circuit Court Judge ruled against the Company and ordered the question of damages be tried before a jury, at a later date. In September 2004, the Company entered into an agreement to settle with the plaintiffs. The settlement has received preliminary approval by the Circuit Court. If the settlement receives final approval, all claims of participating class members will be dismissed and the litigation terminated in exchange for settlement consideration. The Company believes it is adequately reserved for the anticipated cost of the settlement and related expenses. As a result, the agreement is not expected to have a material effect on the Company's earnings or results of operations. The Company expects final approval of the settlement by the Circuit Court in December 2004.

The Company is a defendant in a number of other lawsuits in various states, primarily Alabama, alleging misrepresentation of the rating methodology used by the Company with respect to certain MedOne(R) products purchased by the plaintiffs. These lawsuits commonly seek unspecified damages for misrepresentation and emotional distress, in addition to punitive damages. Some of these cases involve multiple plaintiffs. The cases are in various stages of litigation. The Company believes that these lawsuits are unfounded because the Company properly disclosed the nature of the products sold. The Company also believes the subject matter of the lawsuits falls under the primary jurisdiction of state insurance departments. The Company has reached an agreement of settlement regarding a class action lawsuit involving these issues in Alabama and Georgia. Final approval of the settlement has been received from the Alabama Circuit Court, although a motion for reconsideration has been filed and the time for filing an appeal has not yet expired. A Georgia Superior Court, in a separate matter, enjoined the Company from settling with Georgia residents who are members of the class. The Company has appealed to the Georgia Supreme Court and expects the injunction to be overturned. The Company believes it is adequately reserved for the cost of the settlement and related expenses. The Company is vigorously defending itself in the other pending actions.

The Company is involved in various other legal and regulatory actions occurring in the normal course of business. Based on current information, including consultation with outside counsel, management believes any ultimate liability in excess of amounts reserved that may arise from the above-mentioned and all other

legal and regulatory actions would not have a material adverse effect on the Company's consolidated financial position or results of operations. However, management's evaluation of the likely impact of these actions could change in the future and an unfavorable outcome could have a material adverse effect on the Company's consolidated financial position, results of operations or cash flow of a future period.

9. SEGMENT INFORMATION

The Company has two reportable segments: 1) health insurance products; and 2) life insurance products. The Company's health insurance products consist of the following coverages related to preferred provider organization products: MedOne(R) (for individuals and families) and small group medical, self-funded medical, dental and short-term disability. Life products consist primarily of group term life insurance. The "All other" category includes operations not directly related to the business segments and unallocated corporate items (i.e., corporate investment income, interest expense on corporate debt, amortization of intangibles and unallocated overhead expenses). The reportable segments are managed separately because they differ in the nature of the products offered and in profit margins.

The Company evaluates segment performance based on income or loss before income taxes, excluding realized gains and losses on the Company's investment portfolio. The accounting policies of the reportable segments are the same as those used to report the Company's consolidated financial statements. Significant intercompany transactions have been eliminated prior to reporting reportable segment information.

A reconciliation of segment income (loss) before income taxes to consolidated income from continuing operations before income taxes is as follows:

SEGMENT SUMMARY	Three Months Ended September 30,		Nine Sep
(THOUSANDS)	2004	2003	2004
Health segment	$ 10,242	$ 9,833	$ 36,1
Life segment	1,636	1,518	4,7
All other	(2,034)	1,272	(1,2
Income from continuing operations, before tax	$ 9,844	$ 12,623	$ 39,5

Operating results and statistics for each of the Company's segments are as follows:

HEALTH SEGMENT	Three Months Ended September 30,		Nine Se
(THOUSANDS, EXCEPT MEMBERSHIP DATA)	2004	2003	2004

REVENUES			
Insurance premiums	$ 173,003	$ 173,744	$ 521,
Net investment income	1,417	1,596	4,
Other revenue	4,030	3,828	12,
Total revenues	178,450	179,168	538,
EXPENSES			
Medical and other benefits	117,178	118,518	346,
Selling, general and administrative	51,030	50,817	155,
Total expenses	168,208	169,335	502,
Income from continuing operations, before tax	$ 10,242	$ 9,833	$ 36,
Loss ratio	67.7%	68.2%	66
Expense ratio	27.2%	27.0%	27
Combined ratio	94.9%	95.3%	93
Health membership at end of period:			
Fully-insured medical	272,140	270,401	
Self-funded medical	43,218	43,858	
Dental	214,664	226,734	
Total health membership	530,022	540,993	

LIFE SEGMENT	Three Months Ended September 30,		Nine Se
(THOUSANDS, EXCEPT MEMBERSHIP DATA)	2004	2003	2004
REVENUES			
Insurance premiums	$ 2,786	$ 2,991	$ 8,
Net investment income	116	121	
Other revenue	46	71	
Total revenues	2,948	3,183	9,
EXPENSES			
Medical and other benefits	420	700	1,
Selling, general and administrative	892	965	2,
Total expenses	1,312	1,665	4,
Income from continuing operations, before tax	$ 1,636	$ 1,518	$ 4,

Loss ratio	15.1%	23.4%	18
Expense ratio	30.4%	29.9%	30
Combined ratio	45.4%	53.3%	49
Life membership at end of period	127,075	137,395	

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

BUSINESS OVERVIEW

American Medical Security Group, Inc., together with its subsidiary companies (the "Company"), is a provider of individual and small employer group insurance products. The Company's principal product offerings are medical insurance for small employer groups and medical insurance marketed to individuals and their families ("MedOne(R)"). The Company also offers dental, life, prescription drug, disability and accidental death insurance, and provides self-funded benefit administration. The Company has two reportable segments: health insurance products (which accounted for approximately 98% of the Company's total premium revenues for the nine months ended September 30, 2004 and 2003) and life insurance products. The Company markets its products in 33 states and the District of Columbia through independent agents. The Company has approximately 75 sales managers and representatives located in sales offices throughout the United States to support the independent agents. The Company's products generally provide discounts to members that utilize preferred provider organizations with which the Company contracts.

PENDING MERGER WITH PACIFICARE

On September 15, 2004, the Company entered into a definitive agreement with PacifiCare Health Systems, Inc. ("PacifiCare") whereby PacifiCare will acquire all of the outstanding shares of common stock of the Company through a cash merger in which the Company will become a wholly-owned subsidiary of PacifiCare. Under the terms of the merger agreement, PacifiCare will pay $32.75 in cash for each share of the Company's common stock outstanding for a total equity purchase price of approximately $500 million on a fully diluted basis. It is anticipated that the acquisition will be completed following approvals by the Company's shareholders, the Wisconsin Office of the Commissioner of Insurance and the Georgia Department of Insurance, and compliance with the Hart-Scott-Rodino Act, as well as other customary approvals. The Company's statements of operations for the three and nine months ended September 30, 2004 include merger-related transaction costs of approximately $2.6 million.

A special meeting of shareholders will be held December 2, 2004, at which shareholders will be asked to consider and vote upon the proposal to approve the agreement and plan of merger with PacifiCare and the transactions contemplated by the merger agreement. A proxy statement for the special meeting was mailed to shareholders on or about November 1, 2004.

FINANCIAL RESULTS SUMMARY

The Company reported net income of $5.3 million or $0.36 per diluted share for the three months ended September 30, 2004, compared to net income of $8.8 million or $0.61 per diluted share for the corresponding quarter in the prior year. The decrease in quarterly net income resulted primarily from the following: (1) net income for the third quarter of the prior year included a net gain of $0.9 million from discontinued operations related to the sale of the Company's network subsidiary; (2) realized investment gains were higher net of tax in the third quarter of the prior year by $0.9 million, net of tax resulting from a realignment of the Company's investment portfolio; and (3) net income for the third quarter of 2004 includes a charge for merger-related transaction costs of $2.6 million.

For the nine months ended September 30, 2004, the Company reported net income of $24.0 million or $1.64 per diluted share compared to net income for the first nine months of the prior year of $22.0 million or $1.58 per diluted share. Net income for the year was impacted by the items identified in the preceding paragraph, in addition to a settlement of a dispute with the Company's former pharmacy benefits manager related to pricing and prescription drug fees charged to the Company from 1995 through 2002 (the "PBM settlement") in the first quarter of 2004. As a result of the PBM settlement, the Company received a cash payment of $5.9 million and the Company's financial results for the nine months ended September 30, 2004 include a one-time gain of $3.4 million or $0.23 per diluted share, net of taxes and other related expenses.

INSURANCE PREMIUM REVENUE AND MEMBERSHIP

Insurance premium revenue for the three months ended September 30, 2004 decreased to $175.8 million from $176.7 million for the corresponding period in 2003. For the nine months ended September 30, 2004, insurance premium revenue declined to $530.0 million from $534.6 million for the same period of the prior year. The decrease in premium revenue was caused by a decline in membership, coupled with a trend of members choosing lower priced products with higher deductibles and copayments, resulting in lower premiums per member per month. Total health membership, which includes medical and dental members, declined 10,971 members from 540,993 members at September 30, 2003 to 530,022 members at September 30, 2004. The Company's dental membership declined by 12,070 members from September 30, 2003. Medical membership increased slightly in the third quarter of 2004 due to an increase in MedOne membership, partially offset by a decline in the Company's small group line of business.

The impact of rapidly rising health care costs and the cost of health insurance coverage continues to be a major challenge faced by individuals and small business owners, the Company's primary markets. To help alleviate the impact of rising health care costs, the Company has designed product offerings that provide insurance consumers with a greater financial stake in their health care decisions. In exchange for higher deductibles and copayments, the Company's products attempt to offer more affordable premiums. To mitigate the increasing cost of healthcare, small employers are offering health insurance plans with more limited benefits. Management believes this trend is contributing to the decline in dental membership as fewer small businesses are offering dental benefits to employees. Also, employee attrition among existing small employer groups continues to negatively impact the Company's ability to increase membership in the small employer group market.

INVESTMENT INCOME

Net investment income was $3.5 million for the three months ended September 30, 2004, compared to $3.2 million for the same period in 2003. Net investment

income increased for the nine-month period ended September 30, 2004 to $10.5 million from $10.0 million for the same period of the prior year. The increase in net investment income is due primarily to an increase in average invested assets during the period. Realized investment gains from the sale of securities for the three and nine months ended September 30, 2004 decreased by $1.4 and $1.9 million, respectively, compared to the prior year. Realized investment gains and losses fluctuate as the Company takes advantage of market opportunities and realigns its investment portfolio from time to time.

OTHER REVENUE

Other revenue, which primarily consists of administrative fee income from claims processing on self-funded business and other administrative services, increased to $4.1 million for the three months ended September 30, 2004 from $3.9 million for the three months ended September 30, 2003. For the first nine months of 2004, other revenue increased to $12.5 million from $11.8 million for the same period of the prior year. The increase in other revenue is due to an increase in self-funded membership.

LOSS RATIO

The health segment loss ratio improved slightly in the third quarter of 2004 to 67.7%, compared to 68.2% for the third quarter of 2003. For the first nine months, the health segment loss ratio was 66.5% in 2004, compared to 67.9% in 2003. The improvement from the first nine months of the prior year is due primarily to the 1.0% impact of the PBM settlement. The health segment loss ratio is also impacted by a variety of other factors including claims cost trends, product pricing and the cost of litigation. Management closely monitors developments in litigation and emerging trends in claims costs to determine the adequacy and reasonableness of the Company's related reserves, and adjusts such reserves when necessary. The loss ratio for the life segment was favorable at 15.1% for the three months ended September 30, 2004, compared with 23.4% for the corresponding period of the prior year. For the nine months ended September 30, 2004 the life segment improved to 18.5% from 24.1% for the same period of the prior year.

SELLING, GENERAL AND ADMINISTRATIVE EXPENSE RATIO

The selling, general and administrative ("SG&A") expense ratio includes commissions and selling expenses, administrative expenses net of other revenues, and premium taxes and assessments. The SG&A expense ratio for the health segment for the three months ended September 30, 2004 was 27.2%. This compares to the third quarter of 2003 health segment SG&A expense ratio of 27.0%.

EFFECTIVE TAX RATE

The effective tax rate for three and nine months ended September 30, 2004 was 46.7% and 39.4%, respectively compared to 37.5% and 37.7% for the same respective periods of the prior year. The increase in the effective rate resulted from non-deductible merger-related transaction costs incurred during the third quarter of 2004.

LIQUIDITY AND CAPITAL RESOURCES

The Company's sources of cash flow consist primarily of insurance premiums, administrative fee revenue and investment income. The primary uses of cash include payment of medical and other benefits and SG&A expenses. Positive cash

flows are invested pending future payments of operating expenses; primarily medical and other benefits. The Company's investment policies are structured to provide sufficient liquidity to meet anticipated payment obligations.

The Company's investment portfolio consists almost exclusively of investment grade bonds and has limited exposure to equity securities. At September 30, 2004 and December 31, 2003, greater than 99% of the Company's investment portfolio was invested in debt securities. The bond portfolio had an average quality rating of AA at September 30, 2004 and December 31, 2003, as measured by Standard & Poor's Corporation, and the Company held no below investment grade securities. The majority of the bond portfolio was classified as available for sale. The Company had no investment in mortgage loans, non-publicly traded securities, real estate held for investment or financial derivatives.

The Company's operating cash flow fluctuates from quarter to quarter due to variations in the timing of claims, litigation and other operating payments or recoveries. Cash provided by operations for the third quarter of 2004 was $4.7 million compared to cash provided by operations of $9.1 million in the third quarter of the prior year. Cash provided by operations in the third quarter of 2004 was reduced by payments of litigation settlements in excess of $10.0 million, as well as payments of merger-related transaction costs. For the nine months ended September 30, 2004, cash provided by operations was $11.5 million, compared to cash provided by operations of $7.5 million for the corresponding period in the prior year. The majority of the improvement in cash flow for the nine-month period was due to the receipt of a cash payment of $5.9 million in the first quarter of 2004 resulting from the PBM settlement described above.

The Company maintains a revolving bank line of credit agreement with a maximum available facility of $50.0 million. At September 30, 2004, the outstanding balance of advances under the credit agreement was $30.2 million. The credit agreement requires a lump-sum payment of the outstanding balance at the end of 2005. The credit agreement contains customary covenants which, among other matters, require the Company to achieve certain minimum financial results, prohibit the Company from paying future cash dividends and restrict or limit the Company's ability to incur additional debt and dispose of assets outside the ordinary course of business. The Company was in compliance with all such covenants at September 30, 2004. The Company's obligations under the credit agreement are guaranteed by its subsidiary, American Medical Security Holdings, Inc. ("AMS Holdings"), and secured by pledges of stock of AMS Holdings and United Wisconsin Life Insurance Company ("UWLIC"), the Company's principal insurance subsidiary which is domiciled in Wisconsin.

During the first nine months of 2004, the Company continued its investment in an enterprise-wide information technology modernization project. The project involves the purchase of software applications and the utilization of internal and external technology and resources to support most of the Company's major business processes. Management believes this software investment will help support business growth, operational efficiency, service improvements and future administrative cost savings. The design and development of certain administrative software applications began during the first quarter of 2003 and modules were implemented during 2003 and the first

nine months of 2004, and the remaining implementation is scheduled to be phased in over the next few years. Capital expenditures during the first nine months of 2004 were $6.9 million. In June 2004, the Company amended an agreement with a software vendor resulting in a commitment to purchase software applications and other services to support the Company's core insurance systems. Management believes that the Company's existing working capital and operating cash flow

will be sufficient to fund the Company's anticipated future capital expenditures related to the modernization project.

In January 2003, the Company's Board of Directors approved a share repurchase program, which provides the Company with the authority to repurchase up to $10.0 million of its outstanding common shares. The plan allows the Company to buy back its shares, from time to time, in open market or privately negotiated transactions, subject to price and market conditions. During 2003, the Company purchased 87,900 shares of its common stock at an average market price of $15.44 per share, and at an aggregate cost of $1.4 million. No share repurchases were made by the Company during the first nine months of 2004.

Dividends paid by UWLIC to the corporate parent may be limited by Wisconsin insurance regulations. The insurance regulator may disapprove any dividend which, together with other dividends paid by UWLIC in the prior 12 months, exceeds the regulatory maximum, computed as the lesser of 10% of statutory capital and surplus or total statutory net gain from operations as of the end of the preceding calendar year. In June 2004, a $6.0 million dividend was paid by UWLIC to the corporate parent. Based upon the financial statements of the Company's insurance subsidiaries as of December 31, 2003, as filed with the insurance regulators, the remaining amount available for dividend without regulatory approval is $0.3 million until December 2004, when a dividend of $11.3 million can be paid without regulatory approval.

The National Association of Insurance Commissioners has adopted risk-based capital ("RBC") standards for life and health insurers designed to evaluate the adequacy of statutory capital and surplus in relation to various business risks faced by such insurers. The RBC formula is used by state insurance regulators as an early warning tool to identify insurance companies that potentially are inadequately capitalized. At December 31, 2003, each of the Company's insurance subsidiaries had RBC ratios substantially above the levels that would require Company or regulatory action.

The Company does not expect to pay any cash dividends in the foreseeable future and intends to employ its earnings in the continued development of its business. The Company's future dividend policy will depend on its earnings, capital requirements, debt covenant restrictions, financial condition and other factors considered relevant by the Company's Board of Directors.

Upon the successful completion of the pending merger with PacifiCare, the Company will be obligated to pay a transaction fee for financial advisory services of approximately $4.0 million. In addition, the Company will incur additional merger-related administrative expenses in the process of completing the transaction.

CAUTIONARY FACTORS

This report and other documents or oral presentations prepared or delivered by and on behalf of the Company contain or may contain "forward-looking statements" within the meaning of the safe harbor provisions of the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements based upon management's expectations at the time such statements are made. The Company undertakes no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Forward-looking statements are subject to risks and uncertainties that could cause the Company's actual results to differ materially from those contemplated in the statements. Readers are cautioned not to place undue reliance on the forward-looking statements. When used in written documents or oral presentations, the terms "anticipate," "believe," "estimate," "expect," "may," "objective," "plan," "possible," "potential," "project," "will" and similar expressions are intended to identify forward-looking statements. In

addition to the assumptions and other factors referred to specifically in connection with such statements, factors that could impact the Company's business and financial prospects include, but are not limited to, those discussed below and those discussed from time to time in the Company's various filings with the Securities and Exchange Commission or in other publicly disseminated written documents:

CAUTIONARY FACTORS RELATED TO THE PROPOSED MERGER WITH PACIFICARE

APPROVAL OF THE MERGER. Obtaining regulatory and other approvals may delay or prevent completion of the merger with PacifiCare. Any significant delay in completing the merger could adversely affect the Company.

In addition to obtaining shareholder approval of the merger and the transactions contemplated by the agreement and plan of merger, completion of the merger is conditioned upon, among other things, the termination or expiration of the applicable waiting periods under the Hart-Scott-Rodino Act and the receipt of approval of PacifiCare's acquisition of control of the Company's insurance subsidiaries from each of the Wisconsin Office of the Commissioner of Insurance and the Georgia Department of Insurance. It is possible that one or more of the governmental entities may seek various regulatory concessions or impose conditions for granting approval of the merger. There can be no assurance that the Company or PacifiCare will agree to any such concessions or will be able to satisfy or comply with any such conditions or be able to cause their respective subsidiaries to agree to any such concessions or satisfy or comply with any such conditions.

FAILURE TO COMPLETE MERGER. Failure to complete the merger is likely to negatively impact the Company's stock price and the future business and financial results of the Company.

If the merger is not completed, the ongoing business of the Company may be adversely affected and the Company will be subject to several risks, including (1) being required, under certain circumstances, to pay PacifiCare a termination fee of $17.5 million, (2) having to pay certain costs relating to the merger, such as legal, accounting, financial advisor and printing fees, and (3) the focus of management on the merger instead of on pursuing other opportunities that could be beneficial to the Company, in each case without realizing any of the benefits of having the transaction completed. If the merger is not completed, the Company cannot ensure that these risks will not materialize and will not materially affect the business, financial results and Company's stock price.

CAUTIONARY FACTORS RELATED TO THE COMPANY'S BUSINESS

MEDICAL CLAIMS AND HEALTH CARE COSTS. If the Company is unable to accurately estimate medical claims and control health care costs, its results of operations may be materially adversely affected.

The Company estimates the costs of future medical claims and other expenses using actuarial methods based upon historical data, medical inflation, product mix, seasonality, utilization of health care services and other relevant factors. The Company establishes premiums based on these methods. The premiums the Company charges its customers generally are fixed for one-year periods, and therefore, costs the Company incurs in excess of its medical claim projections generally are not recovered in the contract year through higher premiums. Certain factors may and often do cause actual health care costs to vary from what the Company estimated and reflected in premiums. These factors may include,

but not be limited to: (1) an increase in the rates charged by providers of health care services and supplies, including pharmaceuticals; (2) higher than expected use of health care services by members; (3) the occurrence of bioterrorism, catastrophes or epidemics; (4) changes in the demographics of members and medical trends affecting them; and (5) new mandated benefits or other regulatory changes that increase the Company's costs. The occurrence of any of these factors, which are beyond the Company's control, could result in a material adverse effect on its business, financial condition and results of operations.

GOVERNMENT REGULATIONS. The Company conducts business in a heavily regulated industry and changes in government regulation could increase the costs of compliance or cause the Company to discontinue marketing its products in certain states.

The Company's business is extensively regulated by federal and state authorities. Some of the new federal and state regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, relating to health insurance regulations require the Company to implement changes in its programs and systems in order to maintain compliance. The Company has incurred significant expenditures as a result of HIPAA regulations and expects to continue to incur expenditures as various regulations become effective.

The Company is subject to periodic changes in state laws and regulations regarding the selection and pricing of risks and other matters. New regulations regarding these issues could increase the Company's costs and decrease its premiums. The Company has in the past decided, and may in the future decide, to discontinue marketing its products

in states that have enacted, or are considering, various health insurance regulations that would impair the Company's ability to market its products profitably.

Federal and state legislatures also are considering regulatory measures that may result in higher health insurance costs. Congress is considering legislation allowing small employers to form association health plans, exempt from state insurance regulations, which may impact the risk profile of employers willing to purchase insurance from the Company. Various states occasionally consider community rating legislation that would restrict risk factors that the Company could take into consideration when rating its products, which could impact the profitability of our products and the availability of insurance coverage. In addition, the implementation of "prompt pay" laws, whereby a claim must be paid in a certain number of days regardless of whether it is a valid claim or not, subject to a right of recovery, may have a negative effect on the Company's results of operations.

REGULATORY COMPLIANCE. The Company's failure to comply with new or existing government regulation could subject it to significant fines and penalties.

The Company's efforts to measure, monitor and adjust its business practices to comply with the law are ongoing. Failure to comply with enacted regulations, including the laws mentioned above, could require the Company to pay refunds or result in significant fines, penalties, or the loss of one or more of its licenses. From time to time the Company is subject to inquiries related to its activities and practices in states in which it operates. The Company has been subject to regulatory penalties, assessments and restitution orders in a number of states. Furthermore, federal and state laws and regulations continue to evolve. The costs of compliance may cause the Company to change its operations significantly, or adversely impact the health care provider networks with which

the Company does business, which may adversely affect its business and results of operations.

LITIGATION. The Company is subject to class actions and other forms of litigation in the ordinary course of its business, including litigation based on new or evolving legal theories, which could result in significant liabilities and costs.

For example, the Company recently entered into an agreement to settle a class action lawsuit in which the Florida Circuit Court previously had found the Company liable for damages. The settlement agreement is subject to final approval by the Circuit Court. The Company also recently received final approval from a Alabama Circuit Court of the certification and settlement of a class action lawsuit involving the rating methodology formerly used by the Company for group health benefit plans marketed to individuals in Alabama and Georgia. The Company is involved in a number of other lawsuits in various states that allege misrepresentation by the Company of its renewal rating methodology. For additional information, see Part II, Item 1, "Legal Proceedings."

The nature of the Company's business subjects it to a variety of legal actions and claims relating but not limited to the following: (1) denial of health care benefits; (2) disputes over rating methodology and practices or termination of coverage; (3) disputes with agents over compensation or other matters; (4) disputes related to claim administration errors and failure to disclose network rate discounts and other fee and rebate arrangements; (5) disputes related to managed care or cost containment activities, (6) disputes over co-payment calculations; and (7) customer audits of compliance with the Company's plan obligations.

The Company cannot predict with certainty the outcome of lawsuits against the Company or the potential costs involved.

COMPETITION. Competition in the Company's industry may limit its ability to attract new members or to maintain its existing membership in force. As competitors seek to increase market share, they may lower prices and/or enter the markets in which the Company competes.

The Company operates in a highly competitive environment. The Company competes primarily on the basis of price, benefit plan design, strength of provider networks, quality of customer service, reputation and quality of agent relations. The Company competes for members with other health insurance providers and managed care companies, many of whom have larger membership in regional markets and greater financial resources. Consolidations within the industry may also contribute to the competitive environment. The Company cannot provide assurance that it will be able to compete effectively in this industry. As a result, the Company may be unable to attract new members or maintain its existing membership and its revenues may be adversely affected.

BUSINESS GROWTH STRATEGY. The Company's future operating performance is largely dependent on its ability to execute its growth strategy.

The Company has experienced a decline in membership over the last several years. The Company's challenge is to increase the number of individuals and small employer groups purchasing its products and services and to retain existing members. Also impacting the Company's growth prospects is the affordability of health insurance premiums as health care costs continue to rise, as well as the downsizing or restrained hiring among small employers as a result of economic uncertainty. If the Company's initiatives are not successful and the Company

does not meet its growth goals, the Company's future operating performance may be adversely affected.

INFORMATION SYSTEMS. A failure of the Company's information system could adversely affect its business.

Information processing is critical to the Company's business. The Company depends on its information system for timely and accurate information. The Company's failure to maintain an effective and efficient information system or disruptions in its information system could cause disruptions in its business operations, including any of the following: (1) failure to comply with prompt pay laws; (2) loss of existing members; (3) difficulty in attracting new members; (4) disputes with members, providers and agents; (5) regulatory problems; (6) increases in administrative expenses; and (7) other adverse consequences.

The Company is investing in an enterprise-wide information technology modernization project involving the purchase of software applications to support most of the Company's major processes. The design and development of the software applications began in early 2003, with a phased implementation scheduled over the next few years. Although the Company is taking measures to safeguard against disruptions to its information systems during this process, it cannot provide assurance that disruptions will not occur or that the project will be successfully implemented or implemented on schedule.

INDEPENDENT AGENT RELATIONSHIPS. The Company depends on the services of non-exclusive independent agents and brokers to market its products to potential customers. These agents and brokers frequently market the health insurance products of competitors as well as the Company's products. Most of the Company's contracts with agents and brokers are terminable without cause upon 30-days' notice by either party. The Company faces intense competition for the services and allegiance of independent agents and brokers. The Company cannot provide assurance that they will continue to market the Company's products in the future or that they will not refer the Company's members to competitors.

In addition, the Company has a relationship with a general agent who, along with affiliated subagents, generated approximately 10% of the Company's premium revenue for the nine months ended September 30, 2004. The loss of this relationship could hamper the Company's growth plans and, as a result, adversely affect the Company's future operating performance.

NEGATIVE PUBLICITY. Negative publicity regarding the Company's business practices and about the health insurance industry may harm the Company's business and operating results.

In 2002, the Company was subject to negative national publicity surrounding its MedOne(R) rating practices and related legal matters, which management believes harmed the Company's MedOne(R) new member enrollment during the last half of 2002. The Company changed its rating practices in all MedOne(R) markets effective January 1, 2003. Adverse publicity about the Company's rating practices or other matters in the future may affect sales of the Company's products, which could impede the Company's growth plans.

In addition, the health insurance industry, in general, has received negative publicity and does not have a positive public perception. This publicity and perception may lead to increased legislation, regulation, review of industry practices and private litigation. These factors may adversely affect the Company's ability to market its products and increase the regulatory burdens under which the Company operates, further increasing the costs of doing business and adversely affecting operating results.

INSURANCE RISK MANAGEMENT. If the Company's insurers or reinsurers do not

perform their obligations or offer affordable coverage with reasonable deductibles or limits, the Company could experience significant losses.

The Company's risk management program includes several insurance policies it has purchased to cover various property, business and other risks of loss. In addition, the Company carries policies to cover its directors and officers. Many of the carriers marketing these lines of coverage are experiencing unfavorable claims experience and loss of, or increased costs for, their own reinsurance coverage. Several carriers have exited markets and no longer offer certain lines of coverage. Accordingly, there is no assurance that the Company will be able to purchase insurance coverages for its own risk management at affordable premiums or with reasonable deductibles and policy limits.

The Company has entered into and may continue to enter into a variety of reinsurance arrangements under which it cedes business to other insurance companies to mitigate large claims risk. Although reinsurance allows for greater diversification of risk relating to potential losses arising from large claims, the Company remains liable if these other insurance companies fail to perform their obligations. As a result, any failure of an insurance company to perform its obligations under an agreement could expose the Company to significant losses. Also, there is no assurance that the Company will be able to purchase reinsurance.

PERSONNEL. Loss of key personnel and the inability to attract and retain qualified employees could have a material adverse impact on the Company's operations.

The Company is dependent on the continued services of its management team, including its key executives. Loss of such personnel could have a material adverse effect on the Company. Some of the members of the Company's senior management have developed relationships with some of the Company's independent agents and brokers. If the Company is unable to retain these employees, the loss of their services could adversely impact the Company's ability to maintain relations with certain independent agents and brokers who market the Company's products. Additionally, the Company needs qualified managers and skilled employees with insurance industry experience to operate its businesses successfully. From time to time there may be shortages of skilled labor that may make it more difficult and expensive for the Company to attract and retain qualified employees. If the Company is unable to attract and retain qualified individuals or its costs to do so increase significantly, its operations could be materially adversely affected.

PROVIDER NETWORK RELATIONSHIPS. The Company's inability to enter into or maintain satisfactory relationships with provider networks could harm profitability.

The Company's profitability could be adversely impacted by its inability to contract on favorable terms with networks of hospitals, physicians, dentists, pharmacies and other health care providers. The failure to secure cost-effective health care provider network contracts may result in a loss of membership or higher medical costs. In addition, the inability to contract with provider networks, the inability to terminate contracts with existing provider networks and enter into arrangements with new provider networks to serve the same market, and/or the inability of providers to provide adequate care, could adversely affect the Company's results of operations.

A.M. BEST INSURANCE RATING. If the Company's insurance subsidiaries are not able to maintain their current rating by A.M. Best Company, the Company's results of operations could be materially adversely affected.

The Company's insurance subsidiaries are assigned a rating by A.M. Best Company, a nationally recognized rating agency. The rating reflects A.M. Best Company's opinion of the insurance subsidiaries' financial strength, operating results and ability to meet their ongoing obligations. Decreases in operating performance and other financial measures may result in a downward adjustment of A.M. Best Company's rating of the insurance subsidiaries. In addition, other factors beyond the Company's control such as general downward economic cycles and changes implemented by the rating agencies, including changes in the criteria for the underwriting or the capital adequacy model, may result in a decrease in the rating. A downward adjustment in A.M. Best's rating of the Company's insurance subsidiaries could cause the Company's agents or potential customers to look at the Company with less favor, which could have a material adverse effect on the Company's results of operations.

REGULATION LIMITING TRANSFER OF FUNDS. Regulations governing the Company's insurance subsidiaries could affect its ability to satisfy its obligations to creditors as they become due, including obligations under the Company's credit facility.

The Company's insurance subsidiaries are subject to regulations that limit their ability to transfer funds to the Company. If the Company is unable to obtain funds from its insurance subsidiaries, it will experience reduced cash flow, which could affect the Company's ability to pay its obligations to creditors as they become due. The Company will be required to make a lump-sum payment of the outstanding balance under its credit facility at the end of 2005. The Company's outstanding balance at September 30, 2004 was $30.2 million. If the Company's insurance subsidiaries are unable to provide these funds, the Company could default on its obligations under the credit facility.

CAPITAL AND SURPLUS REQUIREMENTS. If the Company's regulated insurance subsidiaries are not able to comply with state capital standards, state regulators may require the Company to take certain actions that could have a material adverse effect on its results of operations and financial condition.

State regulations govern the amount of capital required to be retained in the Company's regulated insurance subsidiaries and the ability of those regulated subsidiaries to pay dividends. Those state regulations include the requirement to maintain minimum levels of statutory capital and surplus, including meeting the requirements of the risk-based capital standards promulgated by the National Association of Insurance Commissioners. State regulators have broad authority to take certain actions in the event those capital requirements are not met. Those actions could significantly impact the way the Company conducts its business, reduce its ability to access capital from the operations of its regulated insurance subsidiaries and have a material adverse effect on its results of operations and financial condition. Any new minimum capital requirements adopted in the future through state regulation may increase the Company's capital requirements.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The Company's market risk has not substantially changed from the year ended December 31, 2003.

ITEM 4. CONTROLS AND PROCEDURES

The Company's management, with the participation of the Company's Chief

Executive Officer and Chief Financial Officer, has evaluated the effectiveness of the Company's disclosure controls and procedures as of September 30, 2004. Based on that evaluation, the Company's Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective as of September 30, 2004. There were no changes in the Company's internal control over financial reporting during the third quarter of 2004 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

PART II OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

The following report of recent developments in previously reported legal proceedings should be read in conjunction with Item 3, Legal Proceedings, in the Company's annual report on Form 10-K for the year ended December 31, 2003, and quarterly reports on Form 10-Q for the quarters ended March 31, 2004 and June 30, 2004.

On September 23, 2004, two of the Company's wholly owned subsidiaries, American Medical Security, Inc. ("AMS") and United Wisconsin Life Insurance Company ("UWLIC") entered into an agreement to settle a class action lawsuit brought by Evelyn Addison and others, pending in the Circuit Court of Palm Beach County, Florida. The lawsuit was filed in February 2000 and alleges that the Company failed to follow Florida law when in 1998 it discontinued writing certain health insurance policies and offered new policies to insureds. Plaintiffs claim that the Company wrongfully terminated coverage, improperly notified insureds of conversion rights and charged improper premiums for new coverage. Plaintiffs also allege that the Company's renewal rating methodology violated Florida law. In April 2002, the Circuit Court Judge had ruled against the Company and ordered that the question of damages be tried before a jury. The settlement has received preliminary approval by the Circuit Court. If the settlement receives final approval, all claims of participating class members will be dismissed and the litigation terminated in exchange for settlement consideration. The Company believes it is adequately reserved for the anticipated cost of the settlement and related expenses. As a result, the agreement is expected to have no material effect on the Company's earnings or results of operations. The Company expects final approval of the settlement by the Circuit Court in December 2004.

On September 29, 2004, the Circuit Court of Montgomery County, Alabama, granted final approval of the certification and settlement of a class action lawsuit, GADSON V. UNITED WISCONSIN LIFE INSURANCE COMPANY, although a motion for reconsideration has been filed and the time for filing an appeal has not yet expired. The Circuit Court had granted preliminary approval of the certification and settlement in March 2004. The lawsuit was filed in 2001 and involves issues relating to the rating methodology formerly used by the Company for group health benefit plans marketed to individuals in Alabama and Georgia. All claims of participating class members have been dismissed in exchange for the settlement consideration. On June 14, 2004, the Superior Court of Cobb County, Georgia, in PARKER V. AMERICAN MEDICAL SECURITY GROUP, INC., issued an order enjoining the Company from settling with Georgia residents who are members of the Gadson class. On September 2, 2004 the Superior Court certified a class of Georgia residents. The Company believes this injunction and class certification violates general principles of comity and the Full Faith and Credit clause of the United States Constitution and expects the injunction and certification to be overturned by the Georgia Supreme Court, where the Company's appeal of the order is currently pending. The Company believes it is adequately reserved for the

cost of the settlement, including related attorneys' fees.

The Company believes a portion of the cost of settlement of the Florida and Alabama class actions should be covered by insurance. Any potential insurance recovery is not reflected as an asset on the Company's balance sheet.

The Company's subsidiaries, AMS and UWLIC, are defendants in a number of other lawsuits in various states, primarily Alabama, alleging misrepresentation of the rating methodology used by the Company with respect to certain MedOne(R) products purchased by the plaintiffs. These lawsuits commonly seek unspecified damages for misrepresentation and emotional distress, in addition to punitive damages. Some of these cases involve multiple plaintiffs. The cases are in various stages of litigation. The Company believes that these lawsuits are unfounded because the Company properly disclosed the nature of the products sold. The Company also believes the subject matter of the lawsuits falls under the primary jurisdiction of state insurance departments. The Company is vigorously defending itself in these actions.

The Company is involved in various other legal and regulatory actions occurring in the normal course of business. Based on current information, including consultation with outside counsel, management believes any ultimate liability in excess of amounts reserved that may arise from the above-mentioned and all other legal and regulatory actions would not have a material adverse effect on the Company's consolidated financial position or results of operations. However, management's evaluation of the likely impact of these actions could change in the future and an unfavorable outcome could have a material adverse effect on the Company's consolidated financial position, results of operations or cash flow of a future period.

ITEM 6. EXHIBITS AND REPORTS ON FORM 8-K

(a) EXHIBITS

See the Exhibit Index following the signature page of this report, which is incorporated herein by reference.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

DATE: November 4, 2004

AMERICAN MEDICAL SECURITY GROUP, INC.

/s/ John R. Lombardi
John R. Lombardi
Executive Vice President, Chief Financial Officer

and Treasurer (Principal Financial Officer and Chief Accounting Officer and duly authorized to sign on behalf of the Registrant)

AMERICAN MEDICAL SECURITY GROUP, INC.
(the "Registrant")
(Commission File No. 1-13154)

EXHIBIT INDEX
TO
FORM 10-Q QUARTERLY REPORT
for quarter ended September 30, 2004

EXHIBIT NUMBER	DESCRIPTION	INCORPORATED HEREIN BY REFERENCE TO
2	Agreement and Plan of Merger, dated as of September 15, 2004, by and among the Registrant, PacifiCare Health Systems, Inc. and Ashland Acquisition Corp.	Exhibit 2.1 to the Registrant's Form 8 filed with the Securities and Exchange Commission (the "SEC") on September 16 2004
4.1(a)	Rights Agreement, dated as of August 9, 2001 Registrant's by and between the Registrant and Firstar Bank, N.A., as rights agent for (the "Rights Agreement")	Exhibit 1 to the Registrant's Registra Statement on Form 8-A, filed with the on August 14, 2001
4.1(b)	Appointment and Assumption Agreement dated December 17, 2001 by and between the Registrant and Firstar Bank, N.A., appointing LaSalle Bank, N.A. as rights agent for the Rights Agreement	Exhibit 4.2 to the Registrant's Form 8 filed with the SEC on February 5, 2002 (the "2/5/02 8-K")
4.1(c)	Amendment dated as of February 1, 2002 to the Rights Agreement	Exhibit 4.1 to 2/5/02 8-K
4.1(d)	Amendment dated as of June 4, 2002 to the Rights Agreement	Exhibit 4.4(d) to the Registrant's For 8-K filed with the SEC on June 19, 200
4.1(e)	Amendment dated as of September 15, 2004 to the Rights Agreement	Exhibit 4.5 to the Registrant's Registration Statement on Form 8-A (Amendment No. 1) filed with the SEC o September 15, 2004
10.1	Description of the Executive Management 2004 Interim Performance Award	
10.2	Amendment dated September 15, 2004 to Employment Agreement between the Registrant and its Chief Executive Officer	
10.3	Amendment dated as of September 15, 2004 to Deferred Stock Agreement by and between the Registrant and its Chief Executive Officer	

10.4	Amendment dated September 15, 2004 to the Registrant's Change of Control Severance Benefit Plan

EXHIBIT NUMBER	DESCRIPTION	INCORPORATED HEREIN BY REFERENCE TO
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended	
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended	
32	Certification of Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	