AMERICAN MEDICAL SECURITY GROUP INC
Form 10-Q
August 13, 2003

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 JUNE 30, 2003
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 Exchange Act 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 July 31, 2003: 13,255,683 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)	June 30 2003
	(Unaudite

ASSETS	
Investments:	
Fixed maturity securities available for sale, at fair value	$ 286,
Fixed maturity securities held to maturity, at amortized cost	3,
Trading securities, at fair value	1,
Total investments	290,
Cash and cash equivalents	22,
Property and equipment, net	35,
Goodwill, net	32,
Other intangibles, net	2,
Other assets	49,
Total assets	$ 432,
LIABILITIES AND SHAREHOLDERS' EQUITY	
Liabilities:	
Medical and other benefits payable	$ 131,
Advance premiums	16,
Payables and accrued expenses	21,
Notes payable	33,
Other liabilities	27,
Total liabilities	229,
Shareholders' equity:	
Common stock (no par value, $1 stated value, 50,000,000 shares authorized, 16,654,315 issued and 13,253,928 outstanding at June 30, 2003, 16,654,315 issued and 12,905,898 outstanding at December 31, 2002)	16,
Paid-in capital	192,
Retained earnings	16,
Accumulated other comprehensive income (net of taxes of $5,365 at June 30, 2003 and $4,117 at December 31, 2002)	9,
Treasury stock (3,400,387 shares at June 30, 2003 and 3,748,417 shares at December 31, 2002, at cost)	(32,
Total shareholders' equity	202,
Total liabilities and shareholders' equity	$ 432,

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS (Unaudited)

	Three Months Ended June 30,	Six

(THOUSANDS, EXCEPT PER COMMON SHARE DATA)	2003	2002	2003
REVENUES			
Insurance premiums	$ 178,776	$ 190,787	$ 357,
Net investment income	3,345	3,799	6,
Net realized investment gains	91	48	
Other revenue	4,562	4,938	9,
Total revenues	186,774	199,572	374,
EXPENSES			
Medical and other benefits	119,066	129,191	239,
Selling, general and administrative	56,259	61,028	112,
Interest expense	324	463	
Amortization of intangibles	239	182	
Total expenses	175,888	190,864	353,
Income before income taxes and cumulative effect of a change in accounting principle	10,886	8,708	21,
Income tax expense	4,117	3,467	8,
Income before cumulative effect of a change in accounting principle	6,769	5,241	13,
Cumulative effect of a change in accounting principle	-	-	
Net income (loss)	$ 6,769	$ 5,241	$ 13,
Earnings (loss) per common share - basic:			
Income before cumulative effect of a change in accounting principle	$ 0.51	$ 0.42	$
Cumulative effect of a change in accounting principle	-	-	
Net income (loss)	$ 0.51	$ 0.42	$
Earnings (loss) per common share - diluted:			
Income before cumulative effect of a change in accounting principle	$ 0.48	$ 0.38	$
Cumulative effect of a change in accounting principle	-	-	
Net income (loss)	$ 0.48	$ 0.38	$

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS (Unaudited)

(THOUSANDS)	Six 2003
OPERATING ACTIVITIES	
Net income (loss)	$ 13,
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:	
Cumulative effect of a change in accounting principle	
Depreciation and amortization	4,
Net realized investment gains	(
Increase in trading securities	(
Deferred income tax expense (benefit)	
Changes in operating accounts:	
Other assets	(4,
Medical and other benefits payable	(3,
Advance premiums	1,
Payables and accrued expenses	(8,
Other liabilities	(4,
Net cash provided by (used in) operating activities	(1,
INVESTING ACTIVITIES	
Purchases of available for sale securities	(62,
Proceeds from sale of available for sale securities	56,
Proceeds from maturity of available for sale securities	1,
Purchases of held to maturity securities	
Proceeds from maturity of held to maturity securities	
Purchases of property and equipment	(5,
Proceeds from sale of property and equipment	
Net cash provided by (used in) investing activities	(9,
FINANCING ACTIVITIES	
Issuance of common stock	3,
Purchase of treasury stock	(
Repayment of notes payable	(
Net cash provided by (used in) financing activities	2,
Cash and cash equivalents:	
Net decrease	(8,
Balance at beginning of year	30,
Balance at end of period	$ 22,

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

JUNE 30, 2003

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 six months ended June 30, 2003 are not necessarily indicative of the results that may be expected for the year ending December 31, 2003. 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, 2002.

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 10 in the Company's 2002 Annual Report on Form 10-K. The Company follows Accounting Principles Board Opinion No. 25, the intrinsic value method of accounting for stock-based compensation, and no compensation expense is recorded because the exercise price of the Company's employee stock options equaled the market price of the underlying stock on the date of grant. The following table illustrates the pro forma net income and pro forma earnings 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 June 30,		Six M J
(THOUSANDS, EXCEPT PER COMMON SHARE DATA)	2003	2002	2003
Net income (loss), as reported	$ 6,769	$ 5,241	$ 13,2
Pro forma stock compensation expense in accordance with Statement 123, net of tax	(427)	(425)	(8
Pro forma net income (loss)	$ 6,342	$ 4,816	$ 12,4

Net income (loss) per common share, as reported:

Basic	$ 0.51	$ 0.42	$ 1
Diluted	$ 0.48	$ 0.38	$ 0
Pro forma income (loss) per common share:			
Basic	$ 0.48	$ 0.38	$ 0
Diluted	$ 0.45	$ 0.35	$ 0

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. Since 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. NEW ACCOUNTING STANDARD

On January 1, 2002, the Company adopted Statement of Financial Accounting Standards No. 142, GOODWILL AND OTHER INTANGIBLE ASSETS ("Statement 142"). Statement 142 impacts the Company in two ways. First, goodwill is no longer amortized. Second, goodwill was subject to an initial impairment test in accordance with Statement 142, and any remaining balance of goodwill is subject to continuing impairment testing at least annually. Future goodwill impairments, if any, will be classified as operating expenses in the Company's statement of operations. As a result of this initial impairment test, the Company recognized a non-cash goodwill impairment charge of approximately $60.1 million recorded as a cumulative effect of a change in accounting principle as of January 1, 2002. The impairment charge had no impact on cash flows or the statutory-basis capital and surplus of the Company's insurance subsidiaries.

4. 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 employee stock options.

The following table illustrates the computation of EPS for income before cumulative effect of a change in accounting principle and provides a reconciliation of the number of weighted average basic and diluted shares outstanding:

	Three Months Ended June 30,		Six M J
(THOUSANDS, EXCEPT PER COMMON SHARE DATA)	2003	2002	2003

Numerator:			
Income before cumulative effect of a change in accounting principle	$ 6,769	$ 5,241	$ 13,2
Denominator:			
Denominator for basic EPS	13,160	12,615	13,0
Effect of dilutive employee stock options	855	1,066	7
Denominator for diluted EPS	14,015	13,681	13,7
Earnings per common share before cumulative effect of a change in accounting principle:			
Basic	$ 0.51	$ 0.42	$ 1
Diluted	$ 0.48	$ 0.38	$ 0

Certain options to purchase shares of common stock were not included in the computation of diluted earnings per common share for the three and six months ended June 30, 2003 and 2002 because the options' exercise prices were greater than the average market price of the outstanding common shares for the period.

5. COMPREHENSIVE INCOME (LOSS)

Comprehensive income (loss) is defined as net income (loss) plus or minus other comprehensive income (loss). For the Company, under existing accounting standards, other comprehensive income (loss) includes unrealized gains and losses, net of income tax effects, on certain investments in debt and equity securities. Comprehensive income (loss) for the Company is calculated as follows:

	Three Months Ended June 30,		Six M J
(THOUSANDS)	2003	2002	2003
Net income (loss)	$ 6,769	$ 5,241	$ 13,2
Unrealized gain on available for sale securities	1,874	3,125	2,3
Comprehensive income (loss)	$ 8,643	$ 8,366	$ 15,5

6. 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 it discontinued writing certain health insurance policies and offering new policies

in 1998. 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. On April 24, 2002, a Circuit Court Judge ruled against the Company and ordered the question of damages be tried before a jury at a later date. A new judge has been assigned to the case and the parties are awaiting the setting of a trial date. The earliest the Company expects the trial to be held is late first quarter 2004.

In a separate administrative proceeding involving substantially similar facts, the Florida Department of Insurance issued an administrative complaint against the Company in May 2001 challenging certain of the Company's rating and other practices in Florida relating to its MedOne(R) products for individuals and their families. In April 2002, an administrative law judge found in favor of the Company on all issues, held that the evidence presented by the Florida Department of Insurance did not support a conclusion that the Company had violated any provisions of Florida law and recommended that all counts of the complaint be dismissed. In July 2002, the Florida Department of Insurance affirmed the recommendations from the judge with respect to six of eight counts. However, the Department reversed the judge's finding that the Company did not violate state law and ordered the suspension of the Company's license to sell new business in Florida for one year. On April 23, 2003, the First District Court of Appeals for the State of Florida affirmed that the Company did not violate Florida laws through its rating practices and reversed the order by the Florida Department of Insurance. On July 11, 2003, the Court of Appeals denied the Florida Department of Insurance's request for a rehearing. This matter has no direct impact on the class action lawsuit discussed in the previous paragraph.

The Company is a defendant in a number of 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 that may arise from the above-mentioned and all other legal and regulatory actions would not materially affect 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.

7. 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 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 segment information.

A reconciliation of segment income (loss) before income taxes to consolidated income before income taxes and cumulative effect of a change in accounting principle is as follows:

	Three Months Ended June 30,		Six
(THOUSANDS)	2003	2002	2003
Health segment	$ 9,654	$ 8,110	$ 18,7
Life segment	1,524	1,512	2,9
All other	(292)	(914)	(3
Income before income taxes and cumulative effect of a change in accounting principle	$ 10,886	$ 8,708	$ 21,2

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

HEALTH SEGMENT	Three Months Ended June 30,		Six
(THOUSANDS)	2003	2002	2003
REVENUES			
Insurance premiums	$ 175,703	$ 187,314	$ 351,6
Net investment income	1,683	1,809	3,3
Other revenue	3,762	4,063	7,7
Total revenues	181,148	193,186	362,7
EXPENSES			
Medical and other benefits	118,388	128,185	237,9
Selling, general and administrative	53,106	56,891	106,1
Total expenses	171,494	185,076	344,0
Income before income taxes	$ 9,654	$ 8,110	$ 18,7
Loss ratio	67.4%	68.4%	67.
Expense ratio	28.1%	28.2%	28.

Combined ratio	95.5%	96.6%	95.
Health membership at end of period:			
Fully insured medical	275,323	319,675	
Self funded medical	42,568	43,058	
Dental	228,610	235,250	
Total health membership	546,501	597,983	

LIFE SEGMENT	Three Months Ended June 30,		Six
(THOUSANDS)	2003	2002	2003
REVENUES			
Insurance premiums	$ 3,073	$ 3,473	$ 6,2
Net investment income	129	153	2
Other revenue	73	29	1
Total revenues	3,275	3,655	6,6
EXPENSES			
Medical and other benefits	679	1,017	1,5
Selling, general and administrative	1,072	1,126	2,1
Total expenses	1,751	2,143	3,6
Income before income taxes	$ 1,524	$ 1,512	$ 2,9
Loss ratio	22.1%	29.3%	24.
Expense ratio	32.5%	31.6%	32.
Combined ratio	54.6%	60.9%	57.
Life membership at end of period	141,930	166,857	

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

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 97% of the Company's total revenues for the quarters ended June 30, 2003 and 2002) and life insurance products. The Company markets its products in 32 states and the District of Columbia through independent agents. The Company has approximately 75 sales managers located in sales offices throughout the United States to support the independent agents. The Company's products generally provide discounts to insureds that utilize preferred provider organizations. The Company owns a preferred provider network and also contracts with other networks to ensure cost-effective health care choices to its members.

RESULTS OF OPERATIONS

The Company reported net income of $6.8 million or $0.48 per diluted share for the three months ended June 30, 2003, compared to net income of $5.2 million or $0.38 per diluted share for the corresponding period in the prior year. For the six month period ended June 30, 2003, the Company reported net income of $13.2 million or $0.96 per diluted share, compared with income before cumulative effect of a change in accounting principle of $10.7 million or $0.76 per diluted share for the same period of the prior year. Effective January 1, 2002, the Company adopted a new accounting standard. See Note 3 to the Company's Condensed Consolidated Financial Statements for a discussion of the impact of adopting this accounting standard.

The improvement in profitability from the prior year resulted principally from a lower health loss ratio as premiums per member per month continued to increase faster than claims per member per month. The improvement in the loss ratio is primarily attributed to management's strategic actions including increased premium rates on new and renewal business, focused marketing efforts for small employer group products in markets with the best prospects for profitability and future growth, and redesigned products to meet the changing needs of today's insurance consumers.

INSURANCE PREMIUM REVENUE AND MEMBERSHIP

Insurance premium revenue for the three months ended June 30, 2003 decreased 6.3% to $178.8 million from $190.8 million for the corresponding period in 2002. For the six months ended June 30, 2003, insurance premium revenue declined 7.1% to $357.8 million from $385.2 million in the same period of the prior year. The decrease primarily resulted from a decline in membership. Total health membership declined from 597,983 members at June 30, 2002 to 546,501 members at June 30, 2003. Management believes the membership decrease from the prior year is due to several factors, including premium rate increases resulting in lower new sales and higher lapse rates on existing business, negative national publicity surrounding the Company's MedOne(R) rating practices and related legal matters, the difficulty individuals and small employer groups face in affording increasing health insurance premiums and the effect of a declining economy with many employer groups ceasing business or being forced to layoff or downsize their workforce. Partially offsetting the effect of declining membership was the rise in premium rates on the continuing block of business. Net realized average fully insured medical premium per member per month for the second quarter of

2003 increased by 7.8% compared to the second quarter of 2002.

Management is committed to attaining membership and revenue growth through the introduction of innovative products designed to meet the changing needs of today's consumers and through expanded sales support. The Company has introduced new products with flexible benefit designs and has equipped its sales force with an innovative tool to help employers manage their health benefit costs in an inflationary environment. Enhanced customer service programs are also in place to encourage retention of the Company's existing business. Management believes these actions, along with a disciplined approach to pricing and tight expense control, will lead to revenue and membership growth by the end of 2003.

NET INVESTMENT INCOME

Net investment income, including net realized investment gains, was $3.4 million for the three months ended June 30, 2003, compared to $3.8 million for the same period in 2002. Net investment income also declined for the six month period ended June 30, 2003 to $7.2 million from $7.8 million for the same period in the prior year. The decrease in net investment income is due primarily to a decrease in the average annualized investment yield. The average annualized investment yield was 4.9% for the first half of 2003 compared to 5.8% for the first six months of the prior year. The decrease was partially offset by an increase in net realized investment gains of $0.4 million during the first half of 2003.

OTHER REVENUE

Other revenue, which primarily consists of administrative fee income from claim processing on self funded business and other administrative services, decreased to $4.6 million for the three months ended June 30, 2003 from $4.9 million for the three months ended June 30, 2002 resulting from the Company's decrease in membership. On a year-to-date basis, for the first six months, other revenue declined to $9.3 million from $10.3 million for the first six months of 2002.

LOSS RATIO

The health segment loss ratio for the second quarter of 2003 was 67.4% compared to 68.4% for the second quarter of 2002. For the six months ended June 30, the health segment loss ratio was 67.7% in 2003, compared to 68.4% in 2002. The improvement in the health segment loss ratio is due to repricing efforts and claims cost control initiatives. Claims costs per member per month have increased slightly, compared to the same periods in the prior year, but were surpassed by increased premiums per member per month. The loss ratio for the life segment, which represents less than 3% of the Company's total revenues, was favorable at 22.1% for the three months ended June 30, 2003, compared with 29.3% for the corresponding period of the prior year. The Company's loss ratio is also impacted by changes in the estimated cost to settle or resolve claims-related 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.

SELLING, GENERAL AND ADMINISTRATIVE EXPENSE RATIO

The selling, general and administrative ("SG&A") expense ratio includes commissions and selling expenses, administrative expenses (less other revenues), and premium taxes and assessments. The SG&A expense ratio for the health segment for the three months ended June 30, 2003 remained relatively stable at 28.1% compared with 28.2% for the second quarter of the prior year and improved to 28.0% for the six month period ended June 30, 2003 from 28.2% reported for the

same period of 2002. The improvement was the result of management's efforts to control costs as revenues declined.

LIQUIDITY AND CAPITAL RESOURCES

The Company's sources of cash consist primarily of insurance premiums, administrative fee revenue and investment income. The primary uses of cash include payment of medical and other benefits, SG&A expenses and debt service costs. Positive cash flows are invested pending future payments of medical and other benefits and other operating expenses. The Company's investment policies are structured to provide sufficient liquidity to meet anticipated payment obligations.

The Company's cash used in operations was $1.6 million for the six months ended June 30, 2003, compared to cash provided by operations of $3.3 million for the corresponding period in the prior year. The decrease in cash flow resulted from prepaid maintenance fees related to the Company's technology modernization initiatives, as well as other annual expenditures made during the period. Consistent with the Company's historical cash flow trend, management anticipates improved cash flow during the last half of the year.

The Company's investment portfolio consists primarily of investment grade bonds and has limited exposure to equity securities. At June 30, 2003 and December 31, 2002, greater than 99% of the Company's investment portfolio was invested in bonds. The bond portfolio had an average quality rating of AA at June 30, 2003 and December 31, 2002, as measured by Standard & Poor's Corporation. The majority of the bond portfolio was classified as available for sale. The Company has no investment in mortgage loans, non-publicly traded securities, real estate held for investment or financial derivatives.

The Company maintains a revolving bank line of credit agreement with a maximum available facility of $50.0 million. The agreement provides for a lump-sum repayment of outstanding advances at the end of 2005. At June 30, 2003, the outstanding balance of advances under the credit agreement was $30.2 million. 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 June 30, 2003. 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, the Company's principal insurance subsidiary.

The Company's insurance subsidiaries operate in states that require certain levels of regulatory capital and surplus and may restrict the amount of dividends that may be paid to their parent company. The insurance regulator in the insurer's state of domicile may disapprove any dividend which, together with other dividends paid by an insurance company in the prior 12 months, exceeds the regulatory maximum, computed as the lesser of 10% of statutory surplus or total statutory net gain from operations as of the end of the preceding calendar year. Based upon the financial statements of the Company's insurance subsidiaries as of December 31, 2002, as filed with the insurance regulators, the aggregate amount available for dividend without regulatory approval is $11.3 million.

The Company currently does not pay any cash dividends and employs 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.

The National Association of Insurance Commissioners has adopted risk-based capital ("RBC") standards for health and life 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, 2002, each of the Company's insurance subsidiaries had RBC ratios that were substantially above the levels which would require Company or regulatory action.

In an effort to continue supporting business growth, operational efficiency, service improvements and future administrative cost savings, the Company's management approved a plan to invest 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 consulting resources to support most of the Company's major business processes. The design and development of the software applications began during the first quarter of 2003, with a phased implementation scheduled over the next three years. As a result of the information technology modernization project, management anticipates total capital expenditures in 2003 will be approximately $12.0 million. Management believes that the Company's existing working capital, operating cash flow and, if necessary, available facility under its current credit agreement, will be sufficient to fund the Company's anticipated capital expenditures related to this 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. Management expects the share repurchase program will be funded through operating cash flow. During the first quarter of 2003, the Company repurchased 52,700 shares of its common stock at an average market price of $12.46 per share, and at an aggregate cost of $0.7 million. During the second quarter of 2003, the Company did not repurchase any shares of its common stock.

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:

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 its 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 care reform 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 care reform regulations that would impair the Company's ability to market its products profitably.

Federal and state legislatures also are considering health care reform measures, which may result in higher medical 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. 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. The Company has been subject to regulatory penalties, assessments and restitution orders in a number of states in which it operates. For information concerning a regulatory proceeding in Florida, see Part II, Item 1, "Legal Proceedings." From time to time the Company is also subject to inquiries in other states related to its activities and practices. 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, a Florida Circuit Court has found the Company liable for damages in a class action lawsuit in Florida. The parties are awaiting the setting of a trial date to determine damages. Further, the Company is involved in a number of 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 over co-payment calculations; and (6) 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.

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. 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 as part of its strategy to improve profitability and exit certain markets. The Company's challenge is to increase the number of individuals and small employer groups purchasing its products and services while encouraging its current

preferred membership to retain their business relationship with the Company. The Company has expanded and realigned its sales organization, introduced new products, established new distribution channels for its MedOne(R) products, expanded its agent recruitment efforts and developed incentive programs to improve productivity. Also impacting the Company's growth prospects is the affordability of health insurance premiums as health care costs rise and the downsizing of small employer workforces as a result of the soft economy. If the Company 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.

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 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 at affordable premiums.

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 without adequate replacement could have a material adverse effect on the Company. 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

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 it. 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 total principal amount of outstanding balances under its credit facility at the end of 2005. The Company's outstanding balance at June 30, 2003 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, 2002.

ITEM 4. CONTROLS AND PROCEDURES

The Company maintains disclosure controls and procedures designed to ensure that the information the Company must disclose in its filings with the Securities and Exchange Commission is recorded, processed, summarized and reported on a timely basis. The Company's principal executive officer and principal financial officer have reviewed and evaluated the Company's disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act") as of the end of the period covered by this report. Based on such evaluation, such officers have concluded that, as of June 30, 2003, the Company's disclosure controls and procedures are effective in bringing to their attention on a timely basis material information relating to the Company required to be included in the Company's periodic filings under the Exchange Act. There have been no changes in the Company's internal control over financial reporting that occurred during the Company's most recent fiscal quarter 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 fiscal year ended December 31, 2002, and Item 1, Legal Proceedings, in the Company's quarterly report on Form 10-Q for the quarter ended March 31, 2003.

In May 2001 an administrative complaint issued by the Florida Department of Insurance was filed against the Company's wholly owned subsidiary, United Wisconsin Life Insurance Company ("UWLIC") challenging UWLIC's rating and other practices in Florida relating to its MedOne(R) products for individuals and their families. In an order entered April 25, 2002, an Administrative Law Judge recommended dismissal of all counts of the Department's administrative complaint. On July 24, 2002, the Florida Department of Insurance issued a final order affirming the recommendations from the Administrative Law Judge with respect to six of eight counts However, the Department reversed the Administrative Law Judge's finding that the Company did not violate state law applicable to policies issued out of state and ordered the suspension of UWLIC's license to sell new business in Florida for one year. On April 23, 2003, the First District Court of Appeals for the State of Florida (the "Court of Appeals") reversed the order by the Florida Department of Insurance that would have suspended UWLIC's license. Further, on July 11, 2003, the Court of Appeals denied the Florida Department of Insurance's request for a rehearing. The Court of Appeals decision reaffirms the Administrative Law Judge's opinion that UWLIC's rating practices violated no Florida laws as charged in the complaint.

In a separate action involving substantially similar facts, a class action lawsuit was filed against two of the Company's wholly owned subsidiaries, American Medical Security, Inc. ("AMS") and UWLIC in the Circuit Court for Palm Beach County, Florida, by Evelyn Addison and others in February 2002 alleging that the Company failed to follow Florida law when it discontinued writing

certain health insurance policies and offering new policies in 1998. 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 UWLIC's renewal rating methodology violated Florida law. In a final judgment entered April 24, 2002, the Circuit Court Judge in the class action lawsuit found, among other things, that the policy issued by the Company outside Florida was not exempt from any Florida rating laws and ordered that the question of damages be tried before a jury at a later date. A new judge has been assigned to the case and the parties are awaiting the setting of a trial date. The earliest the Company expects the trial to be held is late first quarter 2004. The administrative matter discussed in the preceding paragraph has no direct impact on the class action lawsuit.

The Company's subsidiaries, AMS and UWLIC, are defendants in a number of 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 that may arise from the above-mentioned and all other legal and regulatory actions would not materially affect 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 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

The annual meeting of shareholders of the Company was held on May 21, 2003 for the purpose of (1) electing three directors for terms expiring at the 2006 annual meeting of shareholders, (2) amending the Company's Restated Articles of Incorporation to reduce from 75% to 66-2/3% the requisite shareholder vote to approve future amendments to certain provisions of the Company's Restated Articles of Incorporation, (3) amending the Company's Restated Articles of Incorporation to reduce the size of the Board of Directors from a range of 9 to 15 directors to a range of 8 to 12 directors, (4) amending the Company's Restated Articles of Incorporation to eliminate the designation of Series A Adjustable Rate Nonconvertible Preferred Stock, and (5) amending and re-approving the Company's Executive Annual Incentive Plan.

Shareholders elected all three of the Company's nominees for director, approved the three amendments to the Company's Restated Articles of Incorporation, and amended and re-approved the Company's Executive Annual Incentive Plan. The voting results for the proposals were as follows:

ELECTION OF DIRECTORS FOR TERMS EXPIRING IN 2006:

W. Francis Brennan: Frank L. Skillern:

For	11,374,362 shares	For	11,399,814 shares
Withheld	210,921 shares	Withheld	185,469 shares
Abstained	0	Abstained	0
Broker Non-Votes	0	Broker Non-Votes	0

H.T. Richard Schreyer:

For	11,374,362 shares
Withheld	210,921 shares
Abstained	0
Broker Non-Votes	0

AMENDMENT OF RESTATED ARTICLES OF INCORPORATION TO REDUCE SHAREHOLDER VOTE REQUIRED TO AMEND CERTAIN PROVISIONS OF RESTATED ARTICLES OF INCORPORATION:

For	9,994,109 shares
Against	71,726 shares
Abstained	6,009 shares
Broker Non-Votes	1,513,439 shares

AMENDMENT OF RESTATED ARTICLES OF INCORPORATION TO REDUCE THE SIZE RANGE OF THE BOARD OF DIRECTORS:

For	11,536,049 shares
Against	37,699 shares
Abstained	11,534 shares
Broker Non-Votes	1 shares

AMENDMENT OF RESTATED ARTICLES OF INCORPORATION TO ELIMINATE THE DESIGNATION OF SERIES A PREFERRED STOCK:

For	9,958,881 shares
Against	13,841 shares
Abstained	98,912 shares
Broker Non-Votes	1,513,649 shares

AMENDMENT AND RE-APPROVAL OF EXECUTIVE ANNUAL INCENTIVE PLAN:

For	11,094,058 shares
Against	472,917 shares
Abstained	18,307 shares
Broker Non-Votes	1 shares

Further information concerning these matters, including the names of the directors whose terms continued after the meeting, is contained in the Company's Proxy Statement dated April 7, 2003, with respect to the 2003 annual meeting of shareholders.

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.

(b) REPORTS ON FORM 8-K

The Company filed or submitted the following reports on Form 8-K during the second quarter of 2003:

- A Form 8-K dated April 23, 2003, was filed on April 25, 2003, to report recent developments in a previously reported legal proceeding.

- A Form 8-K dated May 6, 2003, was submitted on May 6, 2003, to furnish the Company's earnings release for the quarter ended March 31, 2003.

After the end of the quarter, the Company submitted a Form 8-K dated August 5, 2003, to furnish the Company's earnings release for the quarter ended June 30, 2003.

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: August 13, 2003

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 June 30, 2003

EXHIBIT NUMBER	DESCRIPTION	INCORPORATED HEREIN BY REFERENCE TO

3.1	Amended and Restated Articles of Incorporation of Registrant dated as of May 27, 2003
3.2	Bylaws of Registrant as amended and restated May 21, 2003
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) or 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

EX-1