

FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
Materials Available on the Web at:
<http://www.floir.com/Sections/GovAffairs/FSC.aspx>

March 29, 2022

MEMBERS
Governor Ron DeSantis
Attorney General Ashley Moody
Chief Financial Officer Jimmy Patronis
Commissioner Nicole “Nikki” Fried

Contact: Grant Phillips
(850-413-2427)

9:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Request for Approval of Minutes of the Financial Services Commission for May 4, 2021.

<http://www.myflorida.com/myflorida/cabinet/agenda21/0202/Transcript.pdf>

(ATTACHMENT 1)

FOR APPROVAL

2. Request for Approval for Publication and Final Adoption of Rules 69O-136.080; .090; .100; Mergers and Acquisition of Controlling Stock of a Florida Domestic Insurer; Merger, Consolidation, or Acquisition of Controlling Stock, Ownership Interests, Assets, or Control of a Specialty Insurer; Forms Incorporated by Reference

Some forms incorporated by reference in 69O-136.080 are revised and the process and forms for a person to attempt to rebut a presumption of control is added to the rule. 69O-136.090 is created concerning the acquisition of controlling stock of a specialty insurer. 69O-136.100 is created for the eventual incorporation of all forms in 69O-136.

(ATTACHMENT 2) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

3. Request for Approval for Publication and Final Adoption of Rule 69O-137.001; Annual and Quarterly Reporting Requirements

This rule is amended to adopt the 2020 National Association of Insurance Commissioners electronic transmission filing instructions, 2019 NAIC's Annual Statement Instructions, the 2020 NAIC's Quarterly Statement Instructions, and the NAIC's Accounting Practices and Procedures Manual as of March 2019 and 2020.

(ATTACHMENT 3) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE

HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

4. Request for Approval for Adoption of Rule 69O-138.001; NAIC Financial Examiners Handbook Adopted

The rule is amended to adopt the 2019 and 2020 National Association of Insurance Commissioners Financial Condition Examiners Handbooks. The current rule adopted the 2017 and 2018 versions of these handbooks.

(ATTACHMENT 4) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

5. Request for Approval for Adoption of Rules 69O-144.001; .002; .004; .005; .006; .007; .009; .011; .012; Purpose; Approval Procedures; Credit for Reinsurance: Authorized Reinsurers; Credit for Reinsurance; Credit for Reinsurance: Reinsurers Maintaining Trust Funds; Credit for Reinsurance From Certified Reinsurers; Credit for Reinsurance: Other Requirements and Provisions; Credit for Reinsurance from Reinsurers Domiciled in Reciprocal Jurisdictions; Term and Universal Life Insurance Reserve Financing

Rule 69O-144.001 is repealed. Rule 69O-144.002 is amended to contain all reinsurance applications and renewals. Rule 69O-144.004 is created to contain requirements for authorized reinsurers. Rule 69O-144.005 is amended to contain requirements for accredited reinsurers. Rule 69O-144.006 is created to contain requirements for reinsurers maintaining trust funds. Rule 69O-144.007 is amended to contain requirements for certified reinsurers. Rule 69O-144.008 is created to implement Chapter 2021-101, Laws of Florida. Rule 69O-144.009 is created to cover requirements that apply to all types of credit for reinsurance. Rule 69O-144.011 is created to cover reinsurers domiciled in reciprocal jurisdictions. 69O-144.012 is created to adopt NAIC Term and Universal Life Insurance Reserve Financing Model Regulation.

(ATTACHMENT 5) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

6. Request for Approval for Adoption of Rule 69O-171.011; Property Claims Litigation Data Call

Chapter 2021-77, Laws of Florida, amended 624.424, F.S., and added subsection (11), which requires the Financial Services Commission to create a form and requires each authorized insurer or insurer group issuing personal lines or commercial lines residential property insurance policies in this state to file with the Office on an annual basis a supplemental property claims litigation report on an individual and group basis for closed claims.

(ATTACHMENT 6) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE

HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

7. Request for Approval for Adoption of Rules 69O-191.021; .027; .028; .075; .085; .097; .107; Scope; Application for Certificate of Authority; Standards for Fingerprint Cards for New Applicants and Acquisition Applications; Annual and Quarterly Reports; Fees; Change of Ownership; Prescribed Forms

Rules 69O-191.021, .028, .097, and .107 are repealed. Rule 69O-191.027 is amended to transfer all aspects of the applications process from other rules in the chapter to one single rule. Rule 69O-191.075 is amended to incorporate the annual reports that must be filed with the Office. Rule 69O-191.085 is amended to delete reference to fees for filing an application.

(ATTACHMENT 7) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

8. Request for Approval for Adoption of Rules 69O-192.001; .008; .048; .058; Purpose and Scope; General Eligibility; Annual Report; Forms Incorporated by Reference

Rules 69O-192.001 and .058 are repealed. Rule 69O-192.008 is amended to transfer all aspects of the applications process from other rules in the chapter to one single rule. Rule 69O-192.048 is amended to incorporate the annual reports that must be filed with the Office. Some forms in the chapter are amended to comply with notary requirement changes due to Chapter 2019-71, Laws of Florida.

(ATTACHMENT 8) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

9. Request for Approval for Adoption of Rules 69O-194.001; .002; .003; .005; .009; .010; .030; Scope; Definitions; Application; Prepaid Health Clinic Contract; Reporting Requirements; Fees; Forms Incorporated by Reference

Rules 69O-194.001 and .030 are repealed. Rules 69O-194.002 and .005 are amended to correct references of "PHAGE" to "PHC." Rule 69O-194.003 is amended to transfer all aspects of the applications process from other rules in the chapter to one single rule. Rule 69O-194.009 is amended to correct references of "PHAGE" to "PHC," delete the Monthly Marketing Statistical Report, and incorporate electronic versions of the annual report. Rule 69O-194.010 is amended to delete reference to the Department of Health.

(ATTACHMENT 9) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

10. Request for Approval for Adoption of Rules 69O-200.001; .002; .004; .006; .009; .011; .014; .015; .017; Purpose and Scope; Definitions; Qualification to Obtain and Hold a License;

Contractual Liability Insurers; Form Filings; Disapproval of Forms; Exemption From Financial Examination; Forms Incorporated by Reference; Annual Reports

Rules 69O-200.001, 69O-200.002, 69O-200.006, 69O-200.014, and 69O-200.015 are repealed. Rule 69O-200.004 is amended to include all applications for motor vehicle service agreement companies in one rule. Rules 69O-200.009 and 69O-200.009 are amended to update the rule language. Rule 69O-200.017 is created concerning annual reports. Some forms in the chapter are amended to comply with notary requirement changes due to Chapter 2019-71, Laws of Florida.

(ATTACHMENT 10) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

11. Request for Approval for Adoption of Rules 69O-202.001; .005; .008; .012; .015; Purpose and Scope; Notification of Acquisition, Merger and Name Change; General Eligibility Requirements; Annual Statement; Forms Incorporated by Reference

Rule 69O-202.001, F.A.C., is repealed because it does not meet the definition of a “rule” under section 120.52(16), F.S. Rule 69O-202.005, F.A.C., is repealed because it is unnecessary. Acquisition of a corporation authorized to accept donor annuity agreements will be controlled by 69O-136.090, F.A.C. Rule 69O-202.008, F.A.C., is amended to update the general eligibility requirements and how Form OIR-C1-1208 is submitted to the Office. Rule 69O-202.012, F.A.C., is amended to update the annual statement requirements and amend the notary block of Form OIR-A3-1209 to comply with notary requirement changes due to Chapter 2019-71, Laws of Florida. Rule 69O-202.015, F.A.C., is repealed due to all the forms being directly incorporated into other rules in the chapter.

(ATTACHMENT 11) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

12. Request for Approval for Adoption of Rules 69O-203.010; .013; .020; .021; .065; .070; .078; .093; .100; .210; .215; Scope; Application for Certificate of Authority; Standards for Fingerprint Cards for New Applicants and Acquisition Applications; Reinsurance (Excess Loss Insurance); Annual and Quarterly Reports; Fees; Change of Ownership; Prescribed Forms; Forms Incorporated by Reference; Annual Reports

Rules 69O-203.010, 69O-021, 69O-203.093, and 69O-203.100, F.A.C., are repealed. Rule 69O-203.013, F.A.C., is amended to remove the definition for “complete application.” Rule 69O-203.020, F.A.C., is amended to contain all application materials for Prepaid Limited Health Service Organizations. Rule 69O-203.065, F.A.C., is amended to update the submission process for filing excess loss or reinsurance contracts with the Office. Rule 69O-203.070, F.A.C., is amended to incorporate the two annual reports and include the Office’s website for how the reports must be filed with the Office. Rule 69O-203.078, F.A.C., is amended to remove references to application filings. Rule 69O-203.210, F.A.C., is amended to make the Discount Plan Organization application rule consistent with other application rules. Rule 69O-203.215, F.A.C., is created to comprise all annual report requirements for Discount Plan Organizations.

(ATTACHMENT 12) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

13. Request for Approval for Adoption of Rules 69O-193.003; .005; .050; .053; Applications and Management Change; Monthly, Quarterly, and Annual Reports; Minimum Liquid Reserve Requirement; Waiver of Minimum Liquid Reserves.

Forms incorporated by reference in all four rules are amended, including some to comply with notary requirement changes due to Chapter 2019-71, Laws of Florida. The order of two forms are amended to be in numerical order.

(ATTACHMENT 13) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

14. Request for Approval for Adoption of Rules 69P-1.001; .002; .011; .012; .013; .014; .015; .016; .017; .018; .019; Plan of Operation and Articles of Agreement Adopted; Assessment Base Determination; Purpose; Definitions; Time for Filing; Content; Test for Deferment; Conditions to Deferred Assessment; Restrictions; Effect on Deferred Assessment; Payments on Surplus Note; Terms of Surplus Note

Chapter 69P-1, F.A.C., concerns the Florida Windstorm Underwriting Association, which no longer exists after it merged with the Florida Residential Property and Casualty Joint Underwriting Association, which later became Citizens Property Insurance Corporation. All eleven rules in the chapter will be repealed.

(ATTACHMENT 14) APPROVAL FOR PUBLICATION OF PROPOSED RULE AND FOR FINAL ADOPTION IF NO MEMBER OF THE PUBLIC TIMELY REQUESTS A RULE HEARING OR IF A HEARING IS REQUESTED AND NO NOTICE OF CHANGE IS NEEDED.

OFFICE OF INSURANCE REGULATION

GOVERNOR DESANTIS: All right. Insurance.

COMMISSIONER ALTMAIER: Good morning,
Governor.

Good morning, Cabinet.

GOVERNOR DESANTIS: Been busy this session
with some of the bills.

COMMISSIONER ALTMAIER: Busy and productive,
yes, sir. Thank you.

So our first agenda item is approval of the
minutes from our February the 2nd meeting at the
Financial Service Commission.

We respectfully request your approval of those
minutes.

GOVERNOR DESANTIS: Move to approve.

Is there a second?

COMMISSIONER FRIED: Second.

GOVERNOR DESANTIS: Any objection?

(NO RESPONSE) .

GOVERNOR DESANTIS: Hearing none, the motion
carries.

COMMISSIONER ALTMAIER: Thank you very much.

Agenda Item No. 2. You may recall we have
undertaken an effort to streamline many of the

1 rules that are associated with our applications
2 process. This is another step in that effort.
3 This provides updates related to the acquisition of
4 specialty insurers.

5 We request your approval to publish, and if no
6 hearing or if no member of the public timely
7 requests a hearing, we'd also ask for your final
8 adoption of that as well for Agenda Item No. 2.

9 GOVERNOR DESANTIS: All right. I move to
10 approve.

11 Is there a second?

12 CFO PATRONIS: Second.

13 COMMISSIONER FRIED: Second.

14 GOVERNOR DESANTIS: Hearing no objection, the
15 motion carries.

16 COMMISSIONER ALTMAIER: Thank you very much.

17 Agenda Items No. 3 through six, we are taking
18 the same action or we are asking to take the same
19 action. These are rules that are returning to the
20 cabinet for the second time. We brought these in
21 February. No member of the public requested a
22 hearing, but we did get some feedback from JAP C on
23 these, which was largely editorial, so we've
24 incorporated those changes into these rules.

25 And for agenda items three through six we

1 respectfully request your final approval.

2 GOVERNOR DESANTIS: Okay. I move to approve
3 those items.

4 Is there a second?

5 COMMISSIONER FRIED: Second.

6 GOVERNOR DESANTIS: Hearing no objections, the
7 motion carries.

8 Thank you.

9 COMMISSIONER ALTMAIER: Thank you.

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69O-136.080 Mergers and Acquisition of Controlling Stock of a Florida Domestic Insurer.

Substantial rewording of Rule 69O-136.080, F.A.C. follows. See Florida Administrative Code for present text.

(1) Any person acquiring a Florida domestic insurer pursuant to section 628.461, F.S., shall comply with the instructions contained on Form OIR-C1-918, incorporated by reference in Rule 69O-136.100, F.A.C., and shall also comply with directions, or otherwise submit, the following applicable forms:

(a) Form OIR-C1-918, incorporated by reference in Rule 69O-136.100, F.A.C.;
(b) Form OIR-C1-905, incorporated by reference in Rule 69O-136.100, F.A.C.;
(c) Form OIR-C1-938, incorporated by reference in Rule 69O-136.100, F.A.C.;
(d) Form OIR-C1-1416, incorporated by reference in Rule 69O-136.100, F.A.C.;
(e) Form OIR-C1-1423, incorporated by reference in Rule 69O-136.100, F.A.C.;
(f) Form OIR-C1-1524, incorporated by reference in Rule 69O-136.100, F.A.C., if required as per the instructions in Form OIR-C1-918;

(g) Form OIR-C1-2221, incorporated by reference in Rule 69O-136.100, F.A.C.;
(h) Form OIR-D0-516, incorporated by reference in Rule 69O-136.100, F.A.C.;
(i) Form OIR-D0-896, incorporated by reference in Rule 69O-136.100, F.A.C.;
(j) Form OIR-D0-904, incorporated by reference in Rule 69O-136.100, F.A.C.;
(k) Form OIR-D0-2119, incorporated by reference in Rule 69O-136.100, F.A.C.;
(l) Form OIR-D0-2165, incorporated by reference in Rule 69O-136.100, F.A.C.; and
(m) Prior to a final decision on whether to approve the proposed acquisition, the Office shall request such other information as is necessary, depending on the facts and circumstances of the specific persons and entities involved, pursuant to section 628.461(3), F.S., to determine the character, experience, ability, and other qualifications required by statute, of the person or affiliated person of such person for the protection of the policyholders and shareholders of the insurer and the public. The Office shall make no final decision on any proposed acquisition without complete information, as required by section 628.461, F.S.

(2) All the forms listed in subsection (1) may be obtained from the Office's website at <http://www.florid.com> and shall be submitted electronically via the Office's iApply system at <https://www.florid.com/iportal>. Forms relating to specific kinds of insurance in subsection (1) are to be submitted only by companies issuing policies relating to the kind of insurance specified on the form.

(3) Any merger effected between or among one or more domestic or foreign stock insurers authorized to transact insurance in this state and one or more other entities authorized to transact insurance and self-insurance in this state, including a self-insurance trust fund existing pursuant to section 627.357, F.S., shall comply with the provisions of sections 628.461 and 628.451, F.S., and this rule.

(4) Any merger effected involving a not-for-profit health maintenance organization that is in a holding company system shall comply with the provisions of sections 628.461, 628.471, 641.255 F.S., and this rule.

(5) Any merger effected involving a for-profit health maintenance organization that is in a holding company system shall comply with sections 628.461, 628.451, 641.255 F.S., and this rule.

(6) A retaliatory application fee shall be submitted pursuant to section 624.5091, F.S. The retaliatory fee is the greater of:

(a) The amount that the applicant's domiciliary state or country would charge a Florida domestic insurer making application in the applicant's state or country of domicile; or

(b) The Florida application fee pursuant to section 624.501(1)(a), F.S.

(7) Disclaimer of Control

(a) A person may attempt to rebut a presumption of control pursuant to section 628.461, F.S., by electronically filing via the Office's iApply system at <https://www.florid.com/iportal> one of the following forms with the Office:

1. Form OIR-C1-1467, incorporated by reference in Rule 69O-136.100, F.A.C.;

2. Form OIR-C1-1468, incorporated by reference in Rule 69O-136.100, F.A.C.;

3. Form OIR-C1-2211, incorporated by reference in Rule 69O-136.100, F.A.C.

(b) A person may attempt to rebut a presumption of control pursuant to section 628.461, F.S., by filing a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended, to the Office electronically via the Office's iApply system at <https://www.florid.com/iportal>.

(c) Pursuant to section 628.461(12)(a), F.S., the Office is authorized to disallow a disclaimer of control filed pursuant to paragraphs (a) and (b).

Rulemaking Authority 624.308(1), 624.413(1), 628.461(13), 628.535 FS. Law Implemented 624.307(1), ~~624.307(3), 624.317, 624.321, 624.34, 624.404, 624.413, 624.424(6), 624.501, 624.5091, 628.051, 628.061, 628.451, 628.461, 628.471, 628.801, 641.255~~ FS. History—New 6-7-90, Formerly 4-109.002, Amended 5-12-94, 11-7-00, Formerly 4-143.056, Amended 5-31-16, Formerly 69O-143.056, Amended, _____.

69O-136.090 Merger, Consolidation, or Acquisition of Controlling Stock, Ownership Interests, Assets, or Control of a Specialty Insurer.

(1) Any person acquiring a specialty insurer pursuant to section 628.4615, F.S., shall comply with the instructions contained on Form OIR-C1-448, incorporated by reference in Rule 69O-136.100, F.A.C., and shall also comply with directions, or otherwise submit, the following applicable forms:

- (a) Form OIR-C1-144, incorporated by reference in Rule 69O-136.100, F.A.C.;
- (b) Form OIR-C1-448, incorporated by reference in Rule 69O-136.100, F.A.C.;
- (c) Form OIR-C1-905, incorporated by reference in Rule 69O-136.100, F.A.C.;
- (d) Form OIR-C1-938, incorporated by reference in Rule 69O-136.100, F.A.C.;
- (e) Form OIR-C1-1423, incorporated by reference in Rule 69O-136.100, F.A.C.;
- (f) Form OIR-C1-2221, incorporated by reference in Rule 69O-136.100, F.A.C.; and,

(g) In addition, prior to a final decision on whether to approve the proposed acquisition, the Office shall request such other information as is necessary, depending on the facts and circumstances of the specific persons and entities involved, pursuant to section 628.4615(4), F.S., to determine the character, experience, ability, and other qualifications required by statute, of the person or affiliated person of such person for the protection of the policyholders and shareholders of the insurer and the public. The Office shall make no final decision on any proposed acquisition without complete information, as required by section 628.4615, F.S.

(2) All the forms listed in subsection (1) may be obtained from the Office's website at <http://www.flair.com> and shall be submitted electronically via the Office's iApply system at <https://www.flair.com/iportal>.

(3) Any merger effected involving a not-for-profit health maintenance organization that is not in a holding company system shall comply with sections 628.4615, 628.471, 641.255 F.S., and this rule.

(4) Any merger effected involving a for-profit health maintenance organization that is not in a holding company system shall comply with sections 628.4615, 628.451, 641.255 F.S., and this rule.

(5) A retaliatory application fee shall be submitted pursuant to section 624.5091, F.S. The retaliatory fee is the greater of:

(a) The amount that the applicant's domiciliary state or country would charge a Florida domestic insurer making application in the applicant's state or country of domicile; or

(b) The Florida application fee pursuant to section 624.501(1)(a), F.S.

(6) Disclaimer of Control

(a) A person may attempt to rebut a presumption of control pursuant to section 628.4615(11), F.S., by electronically filing via the Office's iApply system at <https://www.flair.com/iportal> one of the following forms with the Office:

1. Form OIR-C1-1467, incorporated by reference in Rule 69O-136.100, F.A.C.;

2. Form OIR-C1-1468, incorporated by reference in Rule 69O-136.100, F.A.C.;

3. Form OIR-C1-2211, incorporated by reference in Rule 69O-136.100, F.A.C.

(b) A person may attempt to rebut a presumption of control pursuant to section 628.4615(11), F.S., by filing a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended, to the Office electronically via the Office's iApply system at <https://www.flair.com/iportal>.

(c) Pursuant to section 628.4615(11), F.S., the Office is authorized to disallow a disclaimer of control filed pursuant to paragraphs (a) and (b).

Rulemaking Authority 624.308(1), 628.4615(15), 628.535 FS. Law Implemented 624.307(1), 624.34, 624.424(6), 624.501, 624.5091, 626.9928, 628.451, 628.4615, 628.471 634.252, 634.3073, 634.4085, 636.065, 641.255, 641.416, 642.032, 651.024, 651.0245 FS. History—New _____.

69O-136.100 Forms Incorporated by Reference.

(1) The forms in subsection (2) of this rule are available and may be printed from the Office of Insurance Regulation's website: <https://www.flair.com/iportal>, and are hereby incorporated by reference.

(2)(a) Forms OIR-C1

1. Form OIR-C1-144, "Service of Process Consent & Agreement," effective 6/04, available at www.flrules.org/XXXXX;
2. Form OIR-C1-448, "Application for Acquisition of Controlling Stock, Ownership Interest, Assets, or Control of a Florida Specialty Insurer; Merger or Consolidation," effective 7/21, available at www.flrules.org/XXXXX;
3. Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;
4. Form OIR-C1-918, "Application for Acquisition of Controlling Stock of a Florida Domestic Insurer," effective 7/21, available at www.flrules.org/XXXXX;
5. Form OIR-C1-938, "Fingerprint Payment and Submission Procedure," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;
6. Form OIR-C1-1416, "Uniform Certificate of Authority Application (UCAA) Lines of Insurance," effective 1/20, available at www.flrules.org/XXXXX;
7. Form OIR-C1-1423, "Uniform Certificate of Authority Application (UCAA) Biographical Affidavit," effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;
8. Form OIR-C1-1524, "Disclaimer of Control - Individual," effective 7/21, available at www.flrules.org/XXXXX;
9. Form OIR-C1-1468, "Disclaimer of Control - Entity," 7/21, available at www.flrules.org/XXXXX;
10. Form OIR-C1-1524, "Uniform Certificate of Authority Application (UCAA) Uniform Consent to Service of Process," effective 12/19, available at www.flrules.org/XXXXX;
11. Form OIR-C1-2211, "Disclaimer of Control – Investment Companies," effective 7/21, available at www.flrules.org/XXXXX; and
12. Form OIR-C1-2221, "Management Information Form," effective 6/20, available at www.flrules.org/XXXXX.

(b) Forms OIR-D0

1. Form OIR-D0-516, "Form B Insurance Company System Annual Registration Statement," effective 6/20, available at www.flrules.org/XXXXX;
2. Form OIR-D0-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company," effective 1/19, available at www.flrules.org/XXXXX;
3. Form OIR-D0-904, "UCAA Proforma Financial Statements, Life & Health Insurer," effective 1/19, available at www.flrules.org/XXXXX;
4. Form OIR-D0-2119, "UCAA Proforma Financial Statements, Title Insurance Company," effective 1/19, available at www.flrules.org/XXXXX; and
5. Form OIR-D0-2165, "UCAA Proforma Financial Statements, Health," effective 1/19, available at www.flrules.org/XXXXX.

Rulemaking Authority 624.308(1), 624.413(1), 628.461(13), 628.4615(15), 628.535 FS. Law Implemented 624.307(1), 624.34, 624.404, 624.413, 624.424(6), 624.501, 624.5091, 626.9928, 628.451, 628.461, 628.4615, 628.471, 628.801, 634.252, 634.3073, 634.4085, 636.065, 641.255, 641.416, 642.032, 651.024, 651.0245 FS. History–New _____.

SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

☐ Original Designation ☐ Insurer Name Change ☐ Merger / Acquisition ☐ Update Delivery Information

Insurer or Company Name: _____

Previous Name (If applicable): _____

Home Office Address: _____

City, State, Zip _____

FEI # _____

FL Company Code _____

Telephone # _____

Know all men by these present, that the insurer or other entity named above is subject to the statutory agent for service of process provisions of the Florida Insurance Code duly organized and existing under and by virtue of the laws of the state of domicile.

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in any county in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof.

The undersigned hereby further agrees and stipulates that this agreement is and shall remain irrevocable, so long as there is liability, under any policy, claim or cause of action within this state, either fixed or contingent. Said insurer or other entity does hereby designate the following as the name and address of the person to whom all process is to be forwarded when process is served upon said Chief Financial Officer of the State of Florida on behalf of the above named insurer or entity. **In the event of a change in the name of the insurer or the designation of the person to whom process is to be forwarded, whether it be name, address, and/or phone or fax numbers, the insurer or company shall immediately file a new agreement form with the Chief Financial Officer of the State of Florida at the address shown at the bottom of this page.**

**Designated Person
to receive process:** _____

E-Mail Address: _____

Phone#: _____ **Fax#** _____

Mailing Address: _____

Street Address: _____

Signature: _____

I hereby consent and agree to be the person to whom process served upon the Chief Financial Officer of the State of Florida for said entity, may be forwarded.

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of said insurer or other entity, being duly authorized by the Board of Directors or governing body of this entity to execute this document, have hereunto set our hands and affixed the seal of said insurer or other entity on this the _____ day of _____, A.D. _____.

President or CEO's Signature

President or CEO's Name (Typed or Printed)

SEAL

Secretary's Signature

Secretary's Name (Typed or Printed)

Any signatures other than the President, CEO, or Secretary for the Company must be validated by the attachment of a resolution of the Board of Directors or Governing body of said company delegating the authority to sign for the company.

OIR-C1-144
Rev: 6/2004
Rule 690-136.100



Florida Office of Insurance Regulation

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK,
OWNERSHIP INTEREST, ASSETS, OR CONTROL OF A FLORIDA
SPECIALTY INSURER; MERGER OR CONSOLIDATION**

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in searchable PDF format unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

INSTRUCTIONS

SECTION I - APPLICATION FEES

Section I-1 Application Fees

Applicant must pay the acquisition application fee of \$1,500 U.S. Dollars, pursuant to Section 624.501, Florida Statutes, or an amount otherwise in accordance with Section 624.5091, Florida Statutes. This fee is due at the time the application packet is filed and is not refundable.

Secure your check to the Invoice on page 15 of this application and mail to:

Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

Include copies of the completed Invoice and check with your application filing submitted via iApply. This procedure will expedite the processing of your application and assure a timely recording of the fee payment.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

SECTION II - LEGAL

Section II-1 Description of Transaction

Submit a narrative statement describing the transaction resulting in the acquisition of the controlling stock, ownership interest, assets, or control of a Florida specialty insurer, or a description of the merger or consolidation.

Section II-2 Notification Statement

Provide return receipt cards demonstrating proof of compliance with Section 628.4615(2)(a), Florida Statutes, which requires that the acquiring entity send the letter of notification by registered mail to the principal office of the specialty insurer and any controlling company. Section 628.4615(14)(c), Florida Statutes, defines a controlling company, generally, as an entity holding 25% or more of the voting securities or ownership interests of the specialty insurer.

Section II-3 Furnished the Application

Provide proof that Applicant has furnished the specialty insurer and any controlling company with a copy of the application, pursuant to Section 628.4615(4), Florida Statutes.

Section II-4 Certificate of Status

Submit a certificate of status dated within the last year. A certificate of status is a document issued by the public official having supervision of the records of corporations in the Applicant's home state or jurisdiction of domicile, usually the Secretary of State or equivalent office, and shows that the company is duly organized in the state or jurisdiction of domicile and that all taxes and fees have been paid.

Section II-5 Organizational Documents

Submit a copy of Applicant's organizational or charter documents, such as Articles of Incorporation, Partnership Agreements, Trust Agreements, etc., complete with all amendments, certified within the last year by the public official with whom the originals are on file in the state or jurisdiction of domicile. If the originals are not required to be on file with a public official in the state or jurisdiction of domicile, then the copies should be certified by an appropriate representative of Applicant.

Section II-6 Bylaws

Submit a copy of Applicant's Bylaws, Operating Agreement, Constitution, Rules and Regulations, or similar document. This should be certified by Applicant's Secretary as a true and correct copy of the current document and dated within the last year. Only the Secretary's signature will be accepted, unless the Applicant does not have this position.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

Section II-7 Service of Process Form

Included in this packet is the Service of Process Form (Form OIR-C1-144). This document must be executed and submitted after an acquisition is completed if the information on record with the Office has changed as a result of the transaction.

Section II-8 Statutory Statements

Submit a detailed response to paragraphs (b)-(f) of Section 628.4615(4), Florida Statutes, listed below. Each of these sections should be clearly labelled and responded to individually.

(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.

(c) Any plans or proposals which such persons may have made to liquidate the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals which such persons may have made to liquidate any controlling company of the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.

(d) The nature and the extent of the controlling interest which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the controlling interest is to be acquired of a specialty insurer or controlling company which is not a stock corporation.

(e) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.

(f) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the specialty insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

Section II-9 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

Mergers

If the acquisition is, or includes, the merger of an HMO, Applicant must provide the following in addition to all other items in this application:

Section II-11 Statement of Compliance

If the merger involves a for-profit HMO, submit a statement that Applicant is in compliance with Section 628.451(1), Florida Statutes. If the merger involves a not-for-profit HMO, the statement should instead reference Section 628.471, Florida Statutes.

Section II-12 Confirmation of Voting Results

Submit confirmation of voting results, board resolution, or equivalent documents.

Section II-13 Plan of Merger

Submit a copy of the Plan of Merger.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

SECTION III – FINANCIAL

Section III-1 Applicant's Quarterly Financial Statement

Furnish a copy of Applicant's most recent quarterly financial statement.

Section III-2 Applicant's Annual Financial Statement

Furnish a copy of Applicant's most recent annual financial statement.

Section III-3 Plan of Operation

A specialty insurer licensed in the state of Florida must keep the Office apprised of its business plan. If the proposed acquisition will result in any substantive changes to the operations of the licensee, submit an updated plan of operation as outlined below.

If the subject of the acquisition is not in compliance with Florida Statutes, then a plan to bring the insurer into compliance should be submitted to the Office in this section.

If applicable, Applicant should furnish a three-year Plan of Operations. The plan must include all major areas of the proposed operations and include the following:

- (A) A brief history of the entity since its incorporation.
- (B) A brief description of the management experience of each individual (by name) involved in the operation of the entity.
- (C) A description of products to be offered, broken down by contract type.
- (D) A three-year plan of marketing, including commission rates and the use of sales persons.
- (E) A statement regarding any planned changes in operations during the next three years. If no changes are planned, a statement to that effect.
- (F) In Excel format, a pro forma statutory balance sheet and statutory income and expense statements showing expected premium projections by contract type.
- (G) A list of all assumptions used in projections and pro formas and an explanation of how these assumptions were derived.
- (H) A list of all consultant and expert services in use or proposed during the three-year period.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

Section III-4 Previous Florida Business History of Acquiring Company

In this section the acquiring company should detail its history in the state of Florida.

Section III-5 Purchase Agreements, Tender or Exchange Offers, or Similar Documents

Furnish a copy of all purchase agreements, tender or exchange offers and offering documents, or similar documents associated with the acquisition.

Section III-6 Other Agreements

Furnish copies of any agreements whereby the acquiring entity accepts obligations, debts, and encumbrances which would affect the licensee or are relevant to this transaction. Additionally, furnish copies of any other agreements referenced in this filing.

Section III-7 Organizational Charts

Furnish complete organizational charts for the Applicant and for the specialty insurer. Each set of organizational charts should fully disclose the complete corporate structure and the relationship between all entities, including all parent, holding, subsidiary, and any and all affiliated companies, and must clearly state all ownership percentages if applicable. One set of charts should be submitted for the Applicant and one for the specialty insurer showing each respective organization prior to the proposed acquisition, and another set of charts that shows the Applicant's entire structure after the proposed acquisition.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

SECTION IV - MANAGEMENT

Section IV-1 Management Information Forms

Please submit Management Information Form OIR-C1-2221 fully describing the post-acquisition management, ownership, and control, direct or indirect, of the specialty insurer up to and including any 10% or greater interest holders of the ultimate parent (5% if the transaction involves an HMO). A Management Information Form should be submitted for each entity in the ownership chain.

Forms should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

Section IV-2 Biographical Affidavits as to Officers, Directors, and Shareholders

Provide a National Association of Insurance Commissioners ("NAIC") Biographical Affidavit (NAIC Form 11) (Form OIR-C1-1423) for each individual listed in Section IV-1. Applicant may omit individuals listed for of those entities in the organizational structure between the immediate parent and the ultimate parent. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

All questions must be answered. All "Yes" answers must be explained.

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution, and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

Section IV-3 Background Investigative Report

A Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, included in this packet.

The NAIC approved background investigation vendor list can be found at:

https://www.naic.org/documents/industry_ucaa_third_party.pdf

Section IV-4 Fingerprint Cards

Fingerprint cards must be provided to the Office for each person for whom a Biographical Affidavit is required. Please refer to Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions. If an individual has submitted a fingerprint card dated within 5 years of the date of the Application filing, a fingerprint card need not be submitted for that individual.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

CHECKLIST

SECTION I - APPLICATION FORM & FEES

Applicant Name: _____

Federal Identification Number: _____

Home Office Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

- ☐ 1. Application fee paid (if the entity being acquired holds a COA issued by the Office)
 - ☐ a. Copy of invoice included
 - ☐ b. Copy of check
- ☐ 2. All fingerprint fees paid electronically
 - ☐ a. Copies of online payment confirmation

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

CHECKLIST

SECTION II – LEGAL

- ☐ 1. Description of Transaction
- ☐ 2. Notification Statement
- ☐ 3. Furnishment of Application
- ☐ 4. Certificate of Status
- ☐ 5. Organizational Documents (Articles of Incorporation or equivalent documents)
 - ☐ a. Certified by domiciliary jurisdiction
- ☐ 6. Bylaws (or equivalent documents)
 - ☐ a. Certified by Secretary
- ☐ 7. Service of Process Form (Form OIR-C1-144) (see instructions in II-7)
- ☐ 8. Statutory Statements, Section 628.4615(4)(b)-(f), Florida Statutes
- ☐ 9. Authorization Letter

For Transactions that are, or Involve, HMO Mergers

- ☐ 10. Statement of Compliance
- ☐ 11. Confirmation of Voting Results
- ☐ 12. Plan of Merger

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

CHECKLIST

SECTION III – FINANCIAL

1. Applicant's quarterly financial statement

- ☐ **a.** A copy of Applicant's most recent quarterly financial statement

2. Applicant's annual financial statement

- ☐ **a.** A copy of Applicant's most recent annual financial statement

☐ **3. Plan of Operation**

☐ **4. Applicant's statement of previous Florida business history**

☐ **5. Copies of any purchase agreements, tender or exchange offers, or similar documents**

☐ **6. Copies of other agreements related to the acquisition or referenced in the filing**

7. Organizational Charts

☐ **a.** Chart showing Applicant's organization prior to merger

- ☐ **i.** With ownership percentages

☐ **b.** Chart showing specialty insurer's organization prior to the merger

- ☐ **i.** With ownership percentages

☐ **c.** Chart showing all entities after the merger

- ☐ **i.** With ownership percentages

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

CHECKLIST

SECTION IV – MANAGEMENT

- ☐ 1. Management Information Forms (Form OIR-C1-2221) submitted for all required entities
- ☐ 2. Biographical affidavits (Form OIR-C1-1423) submitted for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. "Yes" answers explained
 - ☐ c. Signed
 - ☐ d. Notarized
- ☐ 3. Background investigative reports for all required individuals. The reports must be based on the Biographical Affidavits submitted to the Office with this Application.
 - ☐ a. Proof of order and confirmation of payment submitted to the Office
- ☐ 4. Fingerprint cards for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. Signed

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

APPLICATION CERTIFICATION

The below certification must be executed by two officers of Applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary*.

The undersigned states that they are officers having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to acquire a Florida insurer, either directly, indirectly, or via merger; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers will be accepted only if Applicant does not have these positions.

**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK, OWNERSHIP INTEREST,
ASSETS, OR CONTROL OF A FLORIDA SPECIALTY INSURER; MERGER OR
CONSOLIDATION**

INVOICE

NAME OF COMPANY: _____

FEIN: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

MAILING ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS ABOVE):

(city)

(state)

(zip code)

1. Make payable to the Department of Financial Services and mail check and invoice only to:
Department of Financial Services,
Bureau of Financial Services,
Post Office Box 6100
Tallahassee, Florida 32314-6100
2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

TYPE: 10 CLASS: 06 Filing Fee: \$1,500.00



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

APPLICATION FOR ACQUISITION OF CONTROLLING STOCK OF A FLORIDA DOMESTIC INSURER

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in searchable PDF format unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

INSTRUCTIONS

SECTION I - APPLICATION FEES

Section I-1 Application Fees

Applicant must pay the acquisition application fee of \$1,500 U.S. Dollars, pursuant to Section 624.501, Florida Statutes, or an amount otherwise in accordance with Section 624.5091, Florida Statutes. This fee is due at the time the application packet is filed and is not refundable.

Secure your check to the Invoice on page 17 of this application and mail to:

Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

Include copies of the completed Invoice and check with your application filing submitted via iApply. This procedure will expedite the processing of your application and assure a timely recording of the fee payment.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions.

SECTION II – LEGAL

Section II-1 **Description of Transaction**

Submit a narrative statement describing the transaction resulting in the acquisition of 10% or more of the outstanding voting securities of a domestic stock insurer, or of the controlling company of a domestic stock insurer.

Section II-2 **Notification Statement**

Submit proof that the acquiring entity has sent to the insurer and any controlling company the notification statement and information required by, and in compliance with, Sections 628.461(1)(a) and 628.461(3), Florida Statutes. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person.

Section II-3 **Certificate of Status**

Submit a certificate of status dated within the last year. A certificate of status is a document issued by the public official having supervision of the records of corporations in the Applicant's home state or jurisdiction of domicile, usually the Secretary of State or equivalent office, that shows the company is duly organized in the state or jurisdiction of domicile and that all taxes and fees have been paid.

Section II-4 **Organizational Documents**

Submit a copy of Applicant's organizational or charter documents, such as Articles of Incorporation, Partnership Agreements, Trust Agreements, etc., complete with all amendments, certified within the last year by the public official with whom the originals are on file in the state or jurisdiction of domicile. If the originals are not required to be on file with a public official in the state or jurisdiction of domicile, then the copies should be certified by an appropriate representative of Applicant.

Section II-5 **Bylaws**

Submit a copy of Applicant's Bylaws, Operating Agreement, Constitution, Rules and Regulations, or similar document. This document should be certified by Applicant's Secretary as a true and correct copy of the current document and dated within the last year. Only the Secretary's signature will be accepted, unless the Applicant does not have this position.

Section II-6 **Statutory Statements**

Submit a detailed response to paragraphs (b)-(g) of Section 628.461(3), Florida Statutes, listed below. Each of these sections should be clearly labelled and responded to individually on a point by point basis.

(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.

(c) Any plans or proposals that such persons may have made to liquidate such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals that such persons may have made to liquidate any controlling company of such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.

(d) The number of shares or other securities that the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.

(e) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.

(f) Effective January 1, 2015, an agreement by the person required to file the statement that the person will provide the annual report specified in s. 628.801(2) if control exists.

(g) Effective January 1, 2015, an acknowledgment by the person required to file the statement that the person and all subsidiaries within the person's control in the insurance holding company system will provide, as necessary, information to the office upon request to evaluate enterprise risk to the insurer.

Section II-7 **Service of Process Form**

Included in this packet is the Service of Process Form (Form OIR-C1-144). This document must be executed and submitted after an acquisition is completed if the information on record with the Office has changed as a result of the transaction.

Section II-8 **Authorization Letter**

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

Mergers

If the acquisition is, or includes, a merger, Applicant must provide the following in addition to all other items in this application:

Section II-9 **Statement of Compliance**

Submit a statement that Applicant is in compliance with Section 628.451(1), Florida Statutes. If the merger involves a not-for-profit HMO, the statement should instead reference Section 628.471, Florida Statutes.

Section II-10 **Confirmation of Voting Results**

Submit confirmation of voting results, board resolution, or equivalent documents.

Section II-11 **Plan of Merger**

Submit a copy of the Plan of Merger.

SECTION III - FINANCIAL

Section III-1 Holding Company Registration Statement

If the Applicant is part of a foreign insurance holding company system, provide a copy of the most recent insurance Holding Company Registration Statement filed with its domiciliary state. Applicant should also provide a draft copy of the prospective post-acquisition Holding Company Registration Statement, as well as a copy of the U.S. Securities and Exchange Commission ("SEC") 10k report if Applicant's Ultimate Controlling Person is required to file with the SEC (most current year, if available).

Section III-2 Applicant's Audited Annual Statements

Furnish copies of the 5 most recent audited financial statements of the Applicant. If Applicant is a natural person, substantially similar information may be required.

Section III-3 Applicant's Quarterly Statement

Furnish a copy of Applicant's most recent quarterly statement.

Section III-4 Applicant's Financial Statement

Furnish a copy of Applicant's unaudited financial statement not older than 90 days of the date of receipt of the Application by the Office.

Section III-5 Ultimate Controlling Person Audited Financial Statements

Furnish copies of the 5 most recent audited financial statements of Applicant's Ultimate Controlling Person. If a natural person, substantially similar information may be required.

Section III-6 Ultimate Controlling Person Financial Statement

Furnish a copy of an unaudited financial statement of Applicant's Ultimate Controlling Person not older than 90 days of the date of receipt of the Application by the Office.

Section III-7 Plan of Operation

An insurer licensed in the state of Florida must keep the Office apprised of its business plan. If the proposed acquisition will result in any substantive changes to the operations of the insurer, submit an updated plan of operation as outlined below. If the proposed acquisition will not result in any substantive changes, then a statement to that effect should be submitted in this section.

If the subject of the acquisition is not in compliance with Florida Statutes, then a plan to bring the insurer into compliance should be submitted to the Office in this section.

If applicable, Applicant should furnish a three-year Plan of Operations for the lines that the insurer is licensed for on the Certificate of Authority. The plan must include all major areas of the proposed operations and include the following:

- (A) A brief history of the company since its incorporation.
- (B) A brief description of the management experience of each individual (by name) involved in the following areas: Marketing, Underwriting, Rating, Reserving, Reinsurance, Claims Handling, Accounting, and Investments.
- (C) A description of insurance products to be offered.
- (D) A three-year plan of marketing, including commission rates and the use of agents.
- (E) A summary of current and planned reinsurance coverage, including catastrophe, and the amount retained on one risk.
- (F) A statement regarding any planned changes in operations during the next three years. If no changes are planned, a statement to that effect.
- (G) In Excel format, a pro forma statutory balance sheet and statutory income and expense statements covering the accounts in the format on the attached forms. Separate forms are included in this packet for Property and Casualty and Life companies, please use the appropriate form.
- (H) A list of all assumptions used in projections and pro formas and an explanation of how these assumptions were derived.
- (I) A list of all consultant and expert services in use or proposed during the three-year period.

Section III-8 **Previous Florida Business History of Acquiring Company**

In this section the acquiring company should detail its history in the state of Florida. Please note if the company has withdrawn from Florida as a whole or discontinued a particular line of business in this state.

Section III-9 **Confirmation of Funds**

Applicant must furnish third-party (bank, approved escrow agent, etc.) written confirmation of the funds necessary to complete the transaction prior to the Office's approval of the acquisition. Provide the confirmation letter in this section for confirmation of funds.

Section III-10 **Purchase Agreements, Tender or Exchange Offers, or Similar Documents**

Furnish a copy of all purchase agreements, tender or exchange offers, and offering documents, or similar documents associated with the transaction.

Section III-11 **Other Agreements**

Furnish copies of any agreements whereby the acquiring company accepts obligations, debts, and encumbrances which would affect the domestic insurer or are relevant to this transaction. Additionally, furnish copies of any other agreements referenced in this filing.

Section III-12 **Organizational Charts**

Furnish complete organizational charts for the Applicant and for the domestic insurer. Each set of organizational charts should fully disclose the complete corporate structure and the relationship between all entities, including all parent, holding, subsidiary, and any and all affiliated companies, and must clearly state all ownership percentages if applicable. One set of charts should be submitted for the Applicant and one for the domestic insurer showing each respective organization prior to the proposed acquisition, and another set of charts that shows the Applicant's entire structure after the proposed acquisition.

SECTION IV - MANAGEMENT

Section IV-1 **Management Information Forms**

Submit Management Information Form OIR-C1-2221 fully describing the post-acquisition management, ownership, and control, direct or indirect, of the domestic insurer up to and including any 10% or greater interest holders of the ultimate parent (5% if the transaction involves an HMO). A Management Information Form should be submitted for each entity in the ownership chain. Provide the same for the surviving company if the transaction is a merger.

Forms should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

Section IV-2 **Biographical Affidavits as to Officers, Directors, and Shareholders**

Provide a National Association of Insurance Commissioners ("NAIC") Biographical Affidavit (NAIC Form 11) (Form OIR-C1-1423) for each individual listed in Section IV-1. Applicant may omit individuals listed for those entities in the organizational structure between the immediate parent and the ultimate parent. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

All questions must be answered. All "Yes" answers must be explained.

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

Section IV-3 **Background Investigative Report**

A Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, included in this packet.

The NAIC approved background investigation vendor list can be found at:

https://www.naic.org/documents/industry_ucaa_third_party.pdf

Section IV-4 **Fingerprint Cards**

Fingerprint cards must be provided to the Office for each person for whom a Biographical Affidavit is required. Please refer to Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions. If an individual has submitted a fingerprint card dated within 5 years of the date of the Application filing, a fingerprint card need not be submitted for that individual.

CHECKLIST

SECTION I - APPLICATION FORM & FEES

Applicant Name: _____

Federal Identification Number ("FEIN"): _____

Home Office Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

- ☐ 1. Application fee paid
 - ☐ a. Copy of invoice included
 - ☐ b. Copy of check
- ☐ 2. All fingerprint fees paid electronically
 - ☐ a. Copies of online payment confirmation

CHECKLIST

SECTION II – LEGAL

- ☐ 1. Description of Transaction
- ☐ 2. Notification Statement
- ☐ 3. Certificate of Status
- ☐ 4. Organizational Documents (Articles of Incorporation or equivalent documents)
 - ☐ a. Certified by domiciliary jurisdiction
- ☐ 5. Bylaws (or equivalent documents)
 - ☐ a. Certified by Secretary
- ☐ 6. Statutory Statements, Section 628.461(3)(b)-(g), Florida Statutes
- ☐ 7. Service of Process Form (Form OIR-C1-144) (see instructions in II-7)
- ☐ 8. Authorization Letter

For Transactions that are, or Involve, Mergers

- ☐ 9. Statement of Compliance
- ☐ 10. Confirmation of Voting Results
- ☐ 11. Plan of Merger

CHECKLIST

SECTION III – FINANCIAL

1. Holding Company Registration Statement, as applicable

- ☐ **a.** Holding Company Registration Statement – acquiring entity
- ☐ **b.** Holding Company Registration Statement – draft prospective for post-acquisition
- ☐ **c.** U.S. Securities and Exchange Commission (“SEC”) 10K report if ultimate parent is required to file with the SEC (most current year, if available)

2. Applicant’s audited annual statements

- ☐ **a.** The most recent 5 statements submitted

3. Applicant’s quarterly statement

- ☐ **a.** A copy of Applicant’s most recent quarterly statement.

4. Applicant’s financial statement

- ☐ **a.** Not older than 90 days of the date of receipt of the Application by the Office

5. Ultimate Controlling Person audited financial statements

- ☐ **a.** The most recent 5 statements submitted

6. Ultimate Controlling Person financial statement

- ☐ **a.** Not older than 90 days of the date of receipt of the Application by the Office

- ☐ **7. Plan of Operations or statement of no changes to the existing Plan of Operation**

- ☐ **8. Applicant’s statement of previous Florida business history**

9. Confirmation of funds

- ☐ **a.** Written confirmation by third-party

- ☐ **10. Copies of any purchase agreements, tender or exchange offers, or similar documents**

- ☐ **11. Copies of other agreements related to the acquisition**

12. Organizational Charts

- ☐ **a.** Chart showing Applicant's organization prior to merger
 - ☐ i. With ownership percentages
- ☐ **b.** Chart showing domestic insurer's organization prior to the merger
 - ☐ i. With ownership percentages
- ☐ **c.** Chart showing all entities after the merger
 - ☐ i. With ownership percentages

CHECKLIST

SECTION IV – MANAGEMENT

- ☐ 1. Management Information Forms (Form OIR-C1-2221) submitted for all required entities
- ☐ 2. Biographical affidavits (Form OIR-C1-1423) submitted for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. "Yes" answers explained
 - ☐ c. Signed
 - ☐ d. Notarized
- ☐ 3. Background investigative reports for all required individuals. The reports must be based on the Biographical Affidavits submitted to the Office with this Application.
 - ☐ a. Proof of order and confirmation of payment submitted to the Office
- ☐ 4. Fingerprint cards for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. Signed

APPLICATION CERTIFICATION

The below certification must be executed by two officers of Applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary*.

The undersigned state that they are officers having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to acquire a Florida insurer, either directly or indirectly; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers will be accepted only if the applicant does not have these positions.

INVOICE

NAME OF COMPANY: _____

FEIN: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

MAILING ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS ABOVE):

(city)

(state)

(zip code)

1. Make payable to the Department of Financial Services and mail check and invoice only to:
Department of Financial Services,
Bureau of Financial Services,
Post Office Box 6100
Tallahassee, Florida 32314-6100
2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

TYPE: 10 CLASS: 06 Filing Fee: \$1,500.00



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail ONLY completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA) Lines of Insurance

Please complete the information below for each state in which the Applicant Company is currently licensed indicating currently authorized, currently transacting and applying for authority to do business. As a result of statutory and regulatory requirements, each state has its own terminology for the lines of insurance. The Lines of Business Matrix was developed to assist the Applicant Company in completing this form. The matrix includes each line of business as it is reported on the NAIC's annual statement blanks and corresponding state statute or regulation. The matrix is located on the UCAA website under State Charts.

ALABAMA	Authorized to Transact	Currently Transacting	Applying for
Life (Sec. 27-5-2), Annuities (Sec. 27-5-3)			
Disability (Sec. 27-5-4)			
HMO (Sec. 27-21A-1, 27-21A-2 and 27-21A-3)			
Property (Sec. 27-5-5)			
Miscellaneous Casualty (Sec. 27-5-6, 27-5-7, 27-5-8, 27-5-9)			
Title (Sec. 27-5-10)			

ALASKA	Authorized to Transact	Currently Transacting	Applying for
Life (AS 21.12.040)			
Health (AS 21.12.050)			
Disability (21.12.052)			
Annuities (AS 21.12.055)			
Variable Life (AS 21.42.370)			
Variable Annuities (AS 21.42.370)			
Property (AS 21.12.060)			
Casualty (AS 21.12.070) including clauses:			
(1) Vehicle			
(2) Liability			
(3) Workers' Compensation and Employers Liability			
(4) Burglary and Theft			
(5) Personal Property Floater			
(6) Glass			
(7) Boiler and Machinery			
(8) Leakage and Fire Extinguishing Equipment			
(9) Credit (failure of debtors to pay obligations to insured)			
(10) Malpractice			
(11) Elevator			
(12) Livestock			
(13) Entertainments			
(14) Miscellaneous			
Surety (AS 21.12.080)			
Marine (AS 21.12.090(a))			
Wet Marine and Transportation (AS 21.12.090(b))			
Mortgage Guaranty (AS 21.12.110)			
Title (AS 21.66)			
Fraternal Benefit Society (AS 21.84)			

ARIZONA	Authorized to Transact	Currently Transacting	Applying for
Casualty with Workers' Compensation A.R.S. § 20-252			
Casualty without Workers' Compensation A.R.S. § 20-252			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

ARIZONA (continued)	Authorized to Transact	Currently Transacting	Applying for
Disability A.R.S. § 20-253			
Life (Includes Annuities) A.R.S. § 20-254			
Variable Annuity A.R.S. § 20-2631(2)			
Variable Life A.R.S. § 20-2601(15)			
Marine and Transportation A.R.S. § 20-255			
Mortgage Guaranty A.R.S. § 20-1541			
Prepaid Legal A.R.S. 20-1097			
Property A.R.S. § 20-256			
Surety A.R.S. § 20-257			
Title A.R.S. § 20-1562			
Vehicle A.R.S. § 20-259			
Life & Disability Reinsurer A.R.S. § 20-1082			
Health Care Services Organization A.R.S. § 20-1051			
Health, Medical, Dental, Optometric Service Corporations A.R.S. § 20-824			
Prepaid Dental Plan Organization A.R.S. § 20-1001			
Recognized Surplus Lines A.R.S. §§ 20-407.01 & 20-409			

ARKANSAS	Authorized to Transact	Currently Transacting	Applying for
Life (ACA 23-62-102)			
Accident & Health (ACA 23-62-103)			
Property (ACA 23-62-104)			
Casualty (ACA 23-62-105)			
Surety (ACA 23-62-106)			
Workers' Compensation (ACA 23-62-105)			
Marine (ACA 23-62-107)			
Title (ACA 23-62-108)			
Mortgage Guaranty (ACA 23-62-110)			
Health Maintenance Organization (23-76-102)			

CALIFORNIA	Authorized to Transact	Currently Transacting	Applying for
Life (CIC 101)			
Fire (CIC 102)			
Marine (CIC 103)			
Title (CIC 104)			
Surety (CIC 105)			
Disability (CIC 106)			
Plate Glass (CIC 107)			
Liability (CIC 108)			
Workers' Compensation (CIC 109)			
Common Carrier Liability (CIC 110)			
Boiler and Machinery (CIC 111)			
Burglary (CIC 112)			
Credit (CIC 113)			
Sprinkler (CIC 114)			
Team and Vehicle (CIC 115)			
Automobile (CIC 116)			
Aircraft (CIC 118)			
Mortgage Guaranty (CIC 119)			
Insolvency (119.5)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

CALIFORNIA (continued)	Authorized to Transact	Currently Transacting	Applying for
Legal (CIC 119.6)			
Miscellaneous (CIC 120)			
Financial Guaranty (CIC 124)			

COLORADO	Authorized to Transact	Currently Transacting	Applying for
Life (10-3-102(1)(b))			
General Life			
Accident and Health			
Annuities			
Credit			
Variable Contracts			
Fraternal Benefit Society (10-14-603)			
General Life			
Accident and Health			
Annuities			
Variable Contracts			
Title (Title 10, Article 11)			
Title			
Property and Casualty (Title 10, Article 3, Sections 102(1)(a), (c) and (d) or (Title 10, Articles 12 or 13)			
General Property			
Crop			
Motor Vehicle			
General Casualty			
Accident and Health			
Fidelity and Surety (excluding bail bond)			
Bail Bond			
Workers' Compensation			
Mortgage Guaranty			
Credit			
Professional Malpractice			

CONNECTICUT	Authorized to Transact	Currently Transacting	Applying for
(C.G.S. Title 38a)			
Fire, Extended Coverage and Other Allied Lines			
Homeowners Multiple Peril			
Commercial Multiple Peril			
Earthquake			
Growing Crops			
Ocean Marine			
Inland Marine			
Accident and Health			
Workers' Compensation			
Liability other than Auto (B.I. and P.D.)			
Auto Liability (B.I. and P.D.)			
Auto Physical Damage			
Aircraft (all perils)			
Fidelity and Surety			
Financial Guaranty (mono-line)			
Glass			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

CONNECTICUT (continued)	Authorized to Transact	Currently Transacting	Applying for
Burglary and Theft			
Boiler and Machinery			
Credit			
Reinsurance			
Life Non-Participating			
Life Participating			
Variable Life Non-Participating			
Variable Life Participating			
Variable Annuities			
Title			
Fraternal Benefit Societies			
Health Care Center			
Credit Life			
Credit Accident and Health			
Mortgage Guaranty (monoline)			
Residual Value			

DELAWARE	Authorized to Transact	Currently Transacting	Applying for
Life [18 Del. C. Section 902]			
Variable Annuities [Del. Reg 1]			
Variable Life [Del. Reg 44]			
Credit Life [18 Del. C. Section 902]			
Credit Health [18 Del. C. Section 903]			
Health [18 Del. C. Section 903]			
Property [18 Del. C. Section 904]			
Surety [18 Del. C. Section 905]			
Casualty [18 Del. C. Section 906(a)], including subdivisions:			
(1) Vehicle			
(2) Liability			
(3) Workers' Compensation & Employer's Liability			
(4) Burglary & Theft			
(5) Personal Property Floater			
(6) Glass			
(7) Boiler & Machinery			
(8) Leakage & Fire Extinguisher Equipment			
(9) Credit			
(10) Malpractice			
(11) Elevator			
(12) Congenital Defects			
(13) Livestock			
(14) Entertainments			
(15) Miscellaneous			
Marine & Transportation [18 Del. C. Section 907]			
Title [18 Del. C. Section 908]			

Presently, lines listed above for casualty are checked off as individual lines on the certificate of authority application form.

18 Del. C. Section 906(b) – Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under subdivisions (1) vehicle, (2) liability, (4) burglary and theft, (7) boiler and machinery, (10) malpractice and (11) elevator of subsection (a) shall for all purposes be deemed to be the same kind of insurance to which it is so incidental and shall not be subject to provisions of this title applicable to life and health insurance.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISTRICT OF COLUMBIA	Authorized to Transact	Currently Transacting	Applying for
Health Maintenance Organizations (Sec. 31 – Chapter 34)			
Life and Health			
Individual Life			
Group Life			
Variable Life (26 DCMR Chapter 27)			
Individual Accident and Health			
Group Accident and Health			
Individual Annuities (Fixed and Variable) (Sec. 31-4442)			
Group Annuities (Fixed and Variable) (Sec. 31-4442)			
Fire and Casualty			
(1) Fire (Sec. 31-2502.11)			
(2.1) Allied Lines (Sec. 31-2502.11)			
(2.2) Multiple Peril Crop			
(2.3) Federal Flood			
(2.4) Private Crop (Sec. 31-2502.11)			
(2.5) Private Flood (Sec. 31-2502.11)			
(3) Farmowners Multiple Peril (Sec. 31-2502.11)			
(4) Homeowners Multiple Peril (Sec. 31-2502.11)			
(5.1) Commercial Multiple Peril (non-liability) (Sec. 31-2502.11)			
(5.2) Commercial Multiple Peril (liability) (Sec. 31-2502.11)			
(6) Mortgage Guaranty			
(8) Ocean Marine (Sec. 31-2502.11)			
(9) Inland Marine (Sec. 31-2502.11)			
(10) Financial Guaranty			
(11) Medical Malpractice (Sec. 31-2502.11)			
(12) Earthquake (Sec. 31-2502.11)			
(13) Group Accident & Health (Sec. 31-2502.11)			
(14) Credit A&H (Group & Individual) (Sec. 31-2502.11)			
(15.1) Collectively Renewable A&H (Sec. 31-2502.11)			
(15.2) Non-cancelable A&H (Sec. 31-2502.11)			
(15.3) Guaranteed Renewable A&H (Sec. 31-2502.11)			
(15.4) Non-Renewable for Stated Reasons Only (Sec. 31-2502.11)			
(15.5) Other Accident Only (Sec. 31-2502.11)			
(15.7) All Other A&H (Sec. 31-2502.11)			
(15.8) Federal Employees Health Benefits Program			
(16) Workers' Compensation (Sec. 31-2502.11)			
(17.1) Other Liability – occurrence (Sec. 31-2502.11)			
(17.2) Other Liability – claims made (Sec. 31-2502.11)			
(18) Products Liability (Sec. 31-2502.11)			
(19.1) Private Passenger Auto No-Fault (personal injury protection) (Sec. 31-2502.11)			
(19.2) Other Private Passenger Auto Liability (Sec. 31-2502.11)			
(19.3) Commercial Auto No-Fault (personal injury protection) (Sec. 31-2502.11)			
(19.4) Other Commercial Auto Liability (Sec. 31-2502.11)			
(20) Glass (Sec. 31-2502.11)			
(21.1) Private Passenger Auto Physical Damage (Sec. 31-2502.11)			
(21.2) Commercial Auto Physical Damage (Sec. 31-2502.11)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISTRICT OF COLUMBIA (continued)	Authorized to Transact	Currently Transacting	Applying for
(22) Aircraft (all perils) (Sec. 31-2502.11)			
(23) Fidelity (Sec. 31-2502.11)			
(24) Surety (Sec. 31-2502.11)			
(26) Burglary and Theft (Sec. 31-2502.11)			
(27) Boiler and Machinery (Sec. 31-2502.11)			
(28) Credit (Sec. 31-2602.03, 31-2502.11)			
Title [Sec. 31-2602.03 (a)(7)]			

FLORIDA	Authorized to Transact	Currently Transacting	Applying for
Property & Casualty Insurers			
0010 Fire			
0020 Allied Lines			
0030 Farmowners Multi Peril			
0040 Homeowners Multi Peril			
0050 Commercial Multi Peril			
0080 Ocean Marine			
0090 Inland Marine			
0100 Financial Guaranty			
* 0106 Auto Warranties			
0110 Medical Malpractice			
0120 Earthquake			
0160 Workers' Compensation			
0170 Other Liability			
* 0173 Prepaid Legal			
0192 Private Passenger Auto Liability			
0194 Commercial Auto Liability			
0211 Private Passenger Auto Physical Damage			
0212 Commercial Auto Physical Damage			
0220 Aircraft			
0230 Fidelity			
0240 Surety			
* 0245 Bail Bonds			
0250 Glass			
0260 Burglary and Theft			
0270 Boiler and Machinery			
0280 Credit			
* 0285 Title (Title Companies Only)			
* 0290 Livestock			
0300 Industrial Fire			
* 0310 Mortgage Guaranty			
0441 Credit Disability			
* 0450 Accident and Health			
* 0520 Industrial Extended Coverage			
* 0540 Mobile Home Multi Peril			
* 0550 Mobile Home Physical Damage			
* 0570 Crop Hail			
* 0607 Home Warranties			
* 0608 Service Warranties			
* 0610 Other Warranty			
* 0620 Miscellaneous Casualty			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

FLORIDA (continued)	Authorized to Transact	Currently Transacting	Applying for
Property & Casualty Insurers (Reinsurance Only)			
R010 Fire			
R020 Allied Lines			
R030 Farmowners Multi Peril			
R040 Homeowners Multi Peril			
R050 Commercial Multi Peril			
R080 Ocean Marine			
R090 Inland Marine			
R100 Financial Guaranty			
* R106 Auto Warranties			
R110 Medical Malpractice			
R120 Earthquake			
R160 Workers' Compensation			
R170 Other Liability			
* R173 Prepaid Legal			
R192 Private Passenger Auto Liability			
R194 Commercial Auto Liability			
R211 Private Passenger Auto Physical Damage			
R212 Commercial Auto Physical Damage			
R220 Aircraft			
R230 Fidelity			
R240 Surety			
* R245 Bail Bonds			
R250 Glass			
R260 Burglary and Theft			
R270 Boiler and Machinery			
R280 Credit			
* R285 Title (Title Companies Only)			
* R290 Livestock			
R300 Industrial Fire			
* R310 Mortgage Guaranty			
R441 Credit Disability			
* R450 Accident and Health			
* R520 Industrial Extended Coverage			
* R540 Mobile Home Multi Peril			
* R550 Mobile Home Physical Damage			
* R570 Crop Hail			
* R607 Home Warranties			
* R608 Service Warranties			
* R610 Other Warranty			
* R620 Miscellaneous Casualty			
Life, Accident and Health Insurers			
0400 Ordinary Life			
Endowment			
Term Life			
Industrial Life			
Individual Annuities			
Universal Life			
0405 Individual Variable Annuities			
Group Variable Annuities			
0410 Group Life and Annuities			
0420 Variable Life			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

FLORIDA (continued)	Authorized to Transact	Currently Transacting	Applying for
0425 Fraternal Life			
0430 Fraternal Health			
0440 Credit Life			
0441 Credit Disability			
0450 Accident and Health			
R400 Reinsurance - Ordinary Life and Annuity			
R405 Reinsurance - Individual/Group Variable Annuities			
R410 Reinsurance - Group Life and Annuity			
R420 Reinsurance - Variable Life			
R440 Reinsurance - Credit Life			
R441 Reinsurance - Credit Disability			
R450 Reinsurance - Accident and Health			

* For purposes of applicant's plan of operations, these lines should be listed as "all other lines." If any are combined with other lines on the proforma (i.e. mobile home combined with homeowners), the plan of operations should specify that this was done.

GEORGIA	Authorized to Transact	Currently Transacting	Applying for
Life, accident, and sickness [O.C.G.A. § 33-3-5(1)]			
Including Variable Annuities [O.C.G.A. § 33-11-66]			
Including Variable Life [O.C.G.A. § 33-11-65]			
Property, marine, and transportation [O.C.G.A. § 33-3-5(2)]			
Casualty [O.C.G.A. § 33-3-5(3)]			
Including Workers' Compensation [O.C.G.A. § 33-7-3]			
Excluding Workers' Compensation [O.C.G.A. § 33-7-3]			
Surety [O.C.G.A. § 33-3-5(4)]			
Title [O.C.G.A. § 33-3-5(5)]			
Health Maintenance Organization [O.C.G.A. § 33-3-5(6) and § 33-21-1 <i>et seq.</i>]			

HAWAII	Authorized to Transact	Currently Transacting	Applying for
Life Insurance (HRS 431:1-204)			
Including Variable Life and Variable Annuity			
Excluding Variable Life and Variable Annuity			
Accident and Health Insurance (HRS 431:1-205)			
Property Insurance (HRS 431:1-206)*			
Including Residential Hurricane (HRS 431:3-306.5)			
Excluding Residential Hurricane			
Marine and Transportation Insurance (HRS 431:1-207)			
Including Ocean Marine (HRS 431:1-211)			
Excluding Ocean Marine			
Vehicle Insurance (HRS 431:1-208)**			
General Casualty Insurance (HRS 431:1-209)* *			
Surety Insurance (HRS 431:1-210)			
Title Insurance (HRS 431:20-102)			

* (1) Concurrently licensed in General Casualty is required; (2) Residential hurricane carrier must also meet the requirements specified in Section 431:3-306.5; information required by this Section needs to be included in the application package. Failure to comply with the Section shall cause exclusion of the residential hurricane coverage.

** Local Claims and Sales Office(s) and membership of Hawaii Joint Underwriting Plan are required for all insurers authorized to write *and engage* in writing vehicle insurance.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

IDAHO	Authorized to Transact	Currently Transacting	Applying for
Life - 41-502			
Disability (Including/Excluding Managed Care) - 41-503			
Variable Annuities/Contracts – 41-502, 41-1938			
Property - 41-504			
Marine and Transportation - 41-505			
Casualty - Including Workers' Compensation - 41-506			
Casualty - Excluding Workers' Compensation - 41-506			
Surety (Including Fidelity) - 41-507			
Monoline only:			
Title - 41-508			
Mortgage Guaranty - 41-2652			

ILLINOIS	Authorized to Transact	Currently Transacting	Applying for
Class 1 Life, Accident and Health*			
(a) Life			
(b) Accident and Health			
(c) Legal Expense Insurance			
Class 2 Casualty, Fidelity and Surety*			
(a) Accident and Health			
(b) Vehicle			
(c) Liability			
(d) Workers' Compensation			
(e) Burglary and Forgery			
(f) Glass			
(g) Fidelity and Surety			
(h) Miscellaneous			
(i) Other Casualty Risks			
(j) Contingent Losses			
(k) Livestock and Domestic Animals			
(l) Legal Expense Insurance			
Class 3 Fire and Marine, etc.*			
(a) Fire			
(b) Elements			
(c) War, Riot and Explosion			
(d) Marine and Transportation			
(e) Vehicle			
(f) Property Damage, Sprinkler Leakage and Crop			
(g) Other Fire and Marine Risks			
(h) Contingent Losses			
(i) Legal Expense Insurance			
Fraternal Benefit Society			
Fraternal Benefit Society [215 ILCS 5/282.1 et seq.]			
Health Maintenance Organization			
Health Maintenance Organization (HMO) [215 ILCS 125/1-1 et seq.]			
Limited Health Service Organization			
Limited Health Service Organization (LHSO) [215 ILCS 130/1001 et seq.]			

* See 215/IL5/4 for additional description

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

INDIANA	Authorized to Transact	Currently Transacting	Applying for
Class I (Life)			
(a) Life and Annuities			
(b) Accident & Health			
(c) Variable Life and Annuities (Segregated Amounts)			
Class II (Casualty)			
(a) Accident and Health - Disability			
(b) Workers' Compensation			
(c) Burglary, Theft			
(d) Glass			
(e) Boiler and Machinery			
(f) Automobile			
(g) Sprinkler			
(h) Liability			
(i) Credit			
(j) Title			
(k) Fidelity & Surety w/Bailbonds			
(kt) Fidelity & Surety w/o Bailbonds			
(l) Miscellaneous			
(m) Legal Expenses			
Class III (Property)			
(a) Fire, Windstorm, Hail, Loot, Riot			
(b) Crops			
(c) Sprinkler			
(d) Marine			

IOWA	Authorized to Transact	Currently Transacting	Applying for
Property/Casualty Lines (515.48)			
Fire			
Extended Coverage			
Other Allied Lines			
Homeowners Multiple Peril			
Commercial Multiple Peril			
Earthquake			
Growing Crops			
Ocean Marine			
Inland Marine			
Accident and Health			
Workers' Compensation			
Other Liability			
Auto Liability			
Auto Physical Damage			
Aircraft			
Fidelity and Surety			
Glass			
Burglary and Theft			
Boiler and Machinery			
Reinsurance Only (monoline)			
Financial Guaranty (monoline)			
Life (508, 509, 511) – Life Only			
Life (508, 509, 511 and 515) credit & variable life, annuities and variable annuities and A&H			
Reciprocal (520)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Iowa (continued)	Authorized to Transact	Currently Transacting	Applying for
Mortgage Guaranty (515C)			
Fraternal (512B)			

*Life includes credit life, variable life, annuities, and variable annuities.

KANSAS	Authorized to Transact	Currently Transacting	Applying for
Life (Includes Annuity and Variable Contracts)			
Accident and Health			
Stand-Alone Prescription Drug Provider			
Fire Insurance			
Fire			
Windstorm & Hail			
Extended Coverage			
Add'l. Perils on Growing Crops			
Hail on Growing Crops			
Optional Perils			
Sprinkler Leakage			
Business Interruption			
Earthquake			
Water Damage			
Aircraft Hull			
Ocean Marine			
Inland Marine			
Rain			
Automobile Physical Damage			
Flood			
Homeowners Policies			
Casualty Insurance			
Accident and Health			
Automobile Liability			
General Liability			
Workers' Compensation			
Fidelity, Surety & Forgery Bonds			
Glass			
Burglary, Theft & Robbery			
Boiler & Machinery			
Credit			
Title			
Malpractice Liability			
Livestock Mortality			
Aircraft Liability			
Cargo Liability			
Cost of Legal Services			
Mortgage Guaranty Insurance			

KENTUCKY	Authorized to Transact	Currently Transacting	Applying for
Life And Health Companies			
Life (includes variable & credit) KRS 304.5-020			
Annuity (includes variable) KRS 304.5-030			
Health (includes credit) KRS 304.5-040			
Property And Casualty Companies			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

KENTUCKY (continued)	Authorized to Transact	Currently Transacting	Applying for
Health (includes credit) KRS 304.5-040			
Property KRS 304.5-050			
Surety KRS 304.5-060			
Casualty All Lines KRS 304.5-070 (1)(a) thru (1)(q)			
Or, Casualty Limited to:			
Vehicle Insurance KRS 304.5-070(1)(a)			
Liability Insurance KRS 304.5-070(1)(b)			
Workers' Compensation and Employers Liability KRS 304.5-070(1)(c)			
Burglary and Theft KRS 304.5-070(1)(d)			
Personal Property Floater KRS 304.5-070(1)(e)			
Glass KRS 304.5-070(1)(f)			
Boiler and Machinery KRS 304.5-070(1)(g)			
Leakage and Fire Extinguishing Equipment KRS 304.5-070(1)(h)			
Credit KRS 304.5-070(1)(i)			
Malpractice KRS 304.5-070(1)(j)			
Elevator KRS 304.5-070(1)(k)			
Congenital Defects KRS 304.5-070(1)(l)			
Livestock KRS 304.5-070(1)(m)			
Entertainments KRS 304.5-070(1)(n)			
Failure of Certain Institutions to Record Documents KRS 304.5-070(o)			
Automobile Guaranty KRS 304.5-070(1)(p)			
Miscellaneous KRS 304.5-070(1)(q)			
Marine and Transportation KRS 304.5-080			
Mortgage Guaranty KRS 304.5-100			
Title KRS 304.5-090			
All Others Companies:			
Fraternal Benefit Society KRS 304.29-011			
Life			
Health			
Lloyd's KRS 304.28-010			
Non-Profit Health Service Corporation KRS 304.32-030			
Reciprocal KRS 304.27-010			

LOUISIANA*	Authorized to Transact	Currently Transacting	Applying for
Life			
Annuities			
Health and Accident			
Vehicle			
Liability			
Workers' Compensation			
Fire and Allied Lines			
Industrial Fire			
Fidelity			
Surety			
Credit Life, Health and Accident			
Credit Property and Casualty			
Marine and Transportation			
Miscellaneous			
Steam Boiler and Sprinkler Leakage			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

LOUISIANA (continued)	Authorized to Transact	Currently Transacting	Applying for
Title			
Burglary and Forgery			
Crop			
Homeowners			

*All lines of business are as defined in Louisiana Revised Statutes 22:47.

MAINE	Authorized to Transact	Currently Transacting	Applying for
Life and Health			
Life, including Credit Life and Annuities			
Health, including Credit Health			
Variable Life			
Variable Annuity			
Property & Casualty			
Fire			
Allied Lines			
Farmowners Multiple Peril			
Homeowners Multiple Peril			
Commercial Multiple Peril			
Mortgage Guaranty			
Ocean Marine			
Inland Marine			
Financial Guaranty			
Workers' Compensation			
Medical Professional Liability			
Earthquake			
Other Liability			
Product Liability			
Auto Liability			
Auto Physical Damage			
Aircraft (all perils)			
Fidelity			
Surety			
Glass			
Burglary and Theft			
Boiler and Machinery			
Credit			
Federal Flood Insurance			
Title			

MARYLAND	Authorized to Transact	Currently Transacting	Applying for
<i>Insurance Article of the Annotated Code of Maryland:</i>			
Variable Annuities – Section 1-101(d)(e), 16-601, 16-602			
Casualty (not including Vehicle Liability, Mortgage Guaranty & Workers' Compensation) – Section 1-101(i)			
Dental Plan Organization – Section 14-401			
Fraternal – 8-424			
Mortgage Guaranty – Sections 1-101(oo)			
Health – Sections 1-101(p)			
Life, including Annuities and Health (except Variable Life & Variable Annuities) Sections 1-101(d), 1-101(p), 1-101(x)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MARYLAND (continued)	Authorized to Transact	Currently Transacting	Applying for
Marine, Wet Marine & Transportation – Sections 1-101(z), 1-101(ss)			
Non-Profit Health Service Plan – Section 14-110			
Property and Marine (excluding Wet Marine and Transportation) – Section 1-101(gg), 1-101(z)			
Variable Life – Sections 16-601, 16-602			
Surety – Section 1-101(oo)			
Title – Section 1-101(qq)			
Vehicle Liability – Section 1-101(i)			
Workers' Compensation – Section 1-101(i)			
<i>Health-General Article of the Annotated Code of Maryland:</i>			
Health Maintenance Organizations – Sections 19-708, 19-709, 19-710			
Provider-Sponsored Organizations – Section 19-7A			

MASSACHUSETTS	Authorized to Transact	Currently Transacting	Applying for
(M.G.L. 175 § 47)			
(1) Fire			
(2A) Ocean Marine			
(2B) Inland Marine Only			
(4) Fidelity and Surety			
(5A) Boiler, Fly Wheel, Machinery, Explosion			
(5B) Boiler (no inspector), Fly Wheel, Machinery, Explosion			
(6A) Accident - All Kinds			
(6B) Health - All Kinds			
(6C) Group Accident and Health Only			
(6D) Non-Cancelable Accident and Health Only			
(6E) Workers' Compensation			
(6F) Liability Other than Auto			
(6G) Auto Liability			
(7) Glass			
(8) Water Damage and Sprinkler Leakage			
(9) Elevator Property Damage and Collision			
(10) Credit			
(11) Title (Title Companies Only)			
(12) Burglary, Robbery, Theft, Forgery, Larceny			
(13) Livestock			
(15) Reinsurance			
(16A) Life - All Kinds			
(16B) Group Life Only			
(16C) Variable Annuity Authorization			
(16D) Annuities Only			
(16E) Variable Life Authorization			
(17) Repair - Replacement			
(19) Legal Services			
(20) Credit Involuntary Unemployment			
(51) Stock Companies Extension of Coverage- M.G.L. 175 §51(g)			
(54) Mutual Companies (specified in Section 47) - M.G.L. 175 § 54(g)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MASSACHUSETTS (continued)	Authorized to Transact	Currently Transacting	Applying for
(54BX) Reinsurance except Life - M.G.L. 175 § 54B			
(54BY) Nuclear Energy - M.G.L. 175 § 54B			
(54BZ) Special Hazards - Radioactive Contamination - M.G.L. 175 § 54B			
(54C) Comprehensive Motor Vehicle and Aircraft - M.G.L. 175 § 54C			
(54D) Personal Property Floater - M.G.L. 175 § 54D			
(54E) Dwellings - M.G.L. 175 § 54E			
(54F) Commercial Property (Multiple Peril) - M.G.L. 175 § 54F			
(54G) Reinsurance - Life Companies Only - M.G.L. 175 § 54G			

MICHIGAN	Authorized to Transact	Currently Transacting	Applying for
Life and Annuity - Other than Variable Contracts (MCL 500.602)			
Separate Account - Variable Annuities (MCL 500.925)			
Separate Account - Variable Life (MCL 500.925)			
Separate Accounts - Modified Guaranteed Annuities (MCL 500.4101)			
Disability (MCL 500.606)			
Property (MCL 500.610)			
Ocean Marine (MCL 500.614)			
Inland Marine (MCL 500.616)			
Automobile Insurance - Limited (MCL 500.620)			
Legal Expense (MCL 500.618)			
Casualty–Steam Boiler, Flywheel and Machinery (MCL 500.624(1)a)			
Casualty–Liability (MCL 500.624(1)b)			
Casualty–Automobile, including Section 500.625, disability coverage supplemental to automobile insurance (MCL 500.624(1)b)			
Casualty–Workers’ Compensation (MCL 500.624(1)b)			
Casualty–Plate Glass (MCL 500.624(1)c)			
Casualty–Sprinkler and Water Damage (MCL 500.624(1)d)			
Casualty–Credit (MCL 500.624(1)e)			
Casualty–Burglary and Theft (MCL 500.624(1)f)			
Casualty–Livestock (MCL 500.624(1)g)			
Casualty–Malpractice (MCL 500.624(1)h)			
Casualty–Miscellaneous (MCL 500.624(1)i)			
Surety and Fidelity (MCL 500.628)			
Limited Liability (MCL 500 Chapter 65)			
Title (MCL 500 Chapter 73)			
Fraternal (MCL 500 Chapter 81a)			

MINNESOTA	Authorized to Transact	Currently Transacting	Applying for
(MS 60A.06, Subd.1)			
Fire (1)			
Inland Marine (2a)			
Ocean Marine (2a)			
Personal Property Floater (2b)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MINNESOTA (continued)	Authorized to Transact	Currently Transacting	Applying for
Boiler and Machinery (3)			
Life (4)			
Variable Contract Authority (4)			
Accident and Health (5a)			
Workers' Compensation (5b)			
Fidelity (6)			
Surety (6)			
Title (7)			
Glass (8)			
Burglary & Theft (9a)			
Security and Drafts (9b)			
Personal Property Floater - Casualty (9c)			
Water (9d)			
Livestock (10)			
Credit (11)			
Automobile (12)			
General Liability (13)			
Elevator (14)			
Legal Expense (15)			

MISSISSIPPI	Authorized to Transact	Currently Transacting	Applying for
(MCA 83-19-1 Classifications of Insurance Companies)			
Class 1. Fire and Casualty			
(a) Fire and Allied Lines			
(b) Industrial Fire			
(c) Casualty/Liability			
(d) Fidelity			
(e) Surety			
(f) Workers' Compensation			
(g) Boiler and Machinery			
(h) Plate Glass			
(i) Aircraft			
(j) Inland Marine			
(k) Ocean Marine			
(l) Automobile Physical Damage/Automobile Liability			
(m) Homeowners/Farmowners			
(n) Guaranty			
(o) Mortgage Guaranty			
(p) Title			
(q) Trip Accident and Baggage			
(r) Legal			
(s) Credit Property			
Class 2. Life			
(a) Life			
(b) Accident and Health			
(c) Credit Life, Credit Accident and Health			
(d) Industrial Life, Industrial Accident and Health			
(e) Variable Contracts			
(f) Life (Burial)			
Class 3. Fraternal			
(a) Fraternal			
(b) Larger Fraternal			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MISSISSIPPI (continued)	Authorized to Transact	Currently Transacting	Applying for
Class 4. Burial			
(MCA 83-41-303) Health Maintenance Organization			

MISSOURI	Authorized to Transact	Currently Transacting	Applying for
A – Life and Health (RSMo 376)			
A1 – Life, Annuities and Endowments (376.010)			
A2 – Accident and Health (376.010)			
A3 – Variable contracts (376.309, RSMo)			
H – Title (RSMo 381)			
B – Property and Casualty (RSMo 379)			
B1 – Property (379.010.1(1))			
B2 – Liability (379.010.1(2)) (Includes Workers' Compensation)			
B3 – Fidelity and Surety (379.010.1(3))			
B4 – Accident and Health (379.010.1(4))			
B5 – Miscellaneous (379.010.1(5))			
Health Maintenance Organization (354.400)			
Prepaid Dental Plan (354.700)			
Fraternal Benefit (378) RSMo			
Other			

MONTANA	Authorized to Transact	Currently Transacting	Applying for
Life (including variable contract authority) § 33-1-208 and 33-20-605, MCA			
Life (excluding variable contract authority) § 33-1-208, MCA			
Disability §33-1-207, MCA			
Property §33-1-210, MCA			
Casualty (including Workers' Comp) §33-1-206, MCA			
Casualty (excluding Workers' Comp) §33-1-206, MCA			
Surety §33-1-211, MCA			
Marine §33-1-209, MCA			
Title §33-1-212, MCA			

NEBRASKA	Authorized to Transact	Currently Transacting	Applying for
Life (1)			
Variable Life (2)			
Variable Annuities (3)			
Sickness & Accident (4)			
Property (5)			
Credit Property (6)			
Glass (7)			
Burglary & Theft (8)			
Boiler & Machinery (9)			
Liability (10)			
Workers' Compensation & Employers Liability (11)			
Vehicle (12)			
Fidelity (13)			
Surety (14)			
Title (15)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NEBRASKA (continued)	Authorized to Transact	Currently Transacting	Applying for
Credit (16)			
Mortgage Guaranty (17)			
Marine (18)			
Financial Guaranty (19)			
Miscellaneous (20)			

NEVADA	Authorized to Transact	Currently Transacting	Applying for
Life (681A.040)			
Health (681A.030)			
Property (681A.060)			
Casualty (681A.020) (Including Workers' Comp)			
Casualty (681A.020) (Excluding Workers' Comp)			
Surety (681A.070)			
Marine and Transportation (681A.050)			
Title (681A.080)			
Surplus Lines (685A)			
Risk Retention Group (695E)			
Funeral/Cemetery Sellers (689)			
Premium Finance Company (686A)			
Motor Clubs (696A)			
Health Maintenance Organization (695C)			
Prepaid Ltd. Health Service Organization (695F)			
Variable (688A)			
Home Protection (690B.100)			

NEW HAMPSHIRE	Authorized to Transact	Currently Transacting	Applying for
Fire and Allied Lines (RSA 401.1, I)			
Marine Coverages (RSA 401.1, II)			
Life and Annuities (RSA 401.1, III)			
Variable Annuities Require a Separate License (RSA 401.1, III)			
Accident and/or Health Coverages (401.1, IV)			
Liability/Casualty Coverages, Including Workers' Compensation (RSA 401.1, V)			
Casualty Coverages (RSA 401.1, VI)			
Fidelity, Surety, Credit Insurance, Mortgage Guaranty, Bonds, and Financial Guaranty (RSA 401.1, VII)			
Other Casualty Risks. Insurance against any other casualty risk not otherwise specified under paragraph V. (RSA 401.1, VIII)			
Title (RSA 416-A)			
Fraternal (RSA 418:16)			

NEW JERSEY	Authorized to Transact	Currently Transacting	Applying for
(1) Fire (N.J.S.A. 17:17-1a)			
(2) Earthquake (N.J.S.A. 17:17-1a)			
(3) Growing Crops (N.J.S.A. 17:17-1a)			
(4) Ocean Marine (N.J.S.A. 17:17-1b)			
(5) Inland Marine (N.J.S.A. 17:17-1b)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NEW JERSEY (continued)	Authorized to Transact	Currently Transacting	Applying for
(6) Workers' Compensation and Employers Liability (N.J.S.A. 17:17-1e)			
(7) Automobile Liability (BI) (N.J.S.A. 17:17-1e)			
(8) Automobile Liability (PD) (N.J.S.A. 17:17-1e)			
(9) Automobile Physical Damage (N.J.S.A. 17:17-1e)			
(10) Aircraft Physical Damage (N.J.S.A. 17:17-1b)			
(11) Other Liability (N.J.S.A. 17:17-1e)			
(12) Boiler & Machinery (N.J.S.A. 17:17-1f)			
(13) Fidelity & Surety (N.J.S.A. 17:17-1g)			
(14) Credit (N.J.S.A. 17:17-1i)			
(15) Burglary & Theft (N.J.S.A. 17:17-1j)			
(16) Glass (N.J.S.A. 17:17-1k)			
(17) Sprinkler Leakage (N.J.S.A. 17:17-1l)			
(18) Livestock (N.J.S.A. 17:17-1m)			
(19) Smoke & Smudge (N.J.S.A. 17:17-1n)			
(20) Physical Loss to Buildings (N.J.S.A. 17:17-1o)			
(21) Radioactive Contamination (N.J.S.A. 17:17-1o)			
(22) Mechanical Breakdown/Power Failure (N.J.S.A. 17:17-1o)			
(23) Other (must be pre-approved by the Commissioner) (N.J.S.A. 17:17-1o)			
(26) Accident and Health (Property/Casualty Companies) (N.J.S.A. 17B:17-4)			
(27) Municipal Bond (N.J.A.C. 11:7)			
(28) Life (N.J.S.A. 17B:17-3)			
(29) Accident and Health (Life/Health Companies) (N.J.S.A. 17B:17-4)			
(30) Annuities (N.J.S.A. 17B:17-5)			
(31) Variable Contracts (N.J.S.A. 17B:28-1 et seq.)			
(33) Title (N.J.S.A. 17:46B-7)			
(34) Fraternal Benefit Society (N.J.S.A. 17:44B)			
(35) Residential Mortgage Guaranty (N.J.S.A. 46A-3)			
(36) Commercial Mortgage Guaranty (N.J.S.A. 46A-3)			

NEW MEXICO	Authorized to Transact	Currently Transacting	Applying for
Life and Annuities (NMSA Section 59A-7-2)			
Accident and Health (NMSA Section 59A-7-3)			
Property (NMSA Section 59A-7-4)			
Casualty (NMSA Section 59A-7-6)			
Variable Life and Annuity (NMSA Section 59A-7-7)			

NEW YORK	Authorized to Transact	Currently Transacting	Applying for
(Notes 1 and 2)			
(Section 1113(a) of the N.Y. Ins. Law)			
(1) Life			
(2) Annuities			
(3) (i) – A&H – Other than Non-Cancellable Disability			
(3) (ii) – A&H – Non-Cancellable Disability			
(4) Fire			
(5) Miscellaneous Property			
(6) Water Damage			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NEW YORK (continued)	Authorized to Transact	Currently Transacting	Applying for
(7) Burglary & Theft			
(8) Glass			
(9) Boiler and Machinery			
(10) Elevator			
(11) Animal			
(12) Collision			
(13) Personal Injury Liability			
(14) Property Damage Liability			
(15) Workers' Compensation and Employers' Liability			
(16) Fidelity and Surety			
(17) Credit			
(19) Motor Vehicle and Aircraft Physical Damage			
(20) Marine and Inland Marine			
(21) Marine Protection and Indemnity			
(22) Residual Value			
(24) Credit Unemployment			
(26) Gap			
(27) Prize Indemnification			
(28) Service Contract Reimbursement			
(29) Legal Services			
(30) Involuntary Unemployment			
(31) Salary Protection			
Monoline only:			
Title – Section 1113(a)(18) & Article 64 of the N.Y. Ins. Law			
Mortgage Guaranty - Section 1113(a)(23) & Article 65 of the N.Y. Ins. Law			
Financial Guaranty - Section 1113(a)(25) & Article 69 of the N.Y. Ins. Law			

Note 1: A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

Note 2: The company must have transacted business for a minimum of three (3) years prior to seeking admission. If the company was recently acquired, at least three (3) years of operating experience under the new management is required. An affiliated insurer admitted in New York and operating under the same ownership/management team for at least three (3) years may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.

NORTH CAROLINA	Authorized to Transact	Currently Transacting	Applying for
Life (NCGS 58-7-15)			
Life, Including Industrial and Credit Life			
Annuities			
Variable Annuities			
Variable Life			
Accident and Health - Cancelable			
Accident and Health - Non-Cancelable			
Accident and Health – Credit			
Fire (NCGS 58-7-15)			
Fire			
Miscellaneous Property - Extended Coverage			
Miscellaneous Property - Growing Crops			
Water Damage – Commercial			
Water Damage - Residence			
Burglary and Theft			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NORTH CAROLINA (continued)	Authorized to Transact	Currently Transacting	Applying for
Glass			
Animal			
Collision – Automobile			
Collision – Other			
Motor Vehicle and Aircraft - Property Damage			
Motor Vehicle and Aircraft - Fire			
Motor Vehicle and Aircraft - Theft			
Motor Vehicle and Aircraft - Comprehensive			
Motor Vehicle and Aircraft - Collision			
Marine – Inland			
Marine – Ocean			
Marine Protection and Indemnity			
Other			
Casualty (NCGS 58-7-15)			
Accident and Health – Cancelable			
Accident and Health – Non Cancelable			
Accident and Health – Credit			
Water Damage – Commercial			
Water Damage – Residence			
Burglary and Theft			
Glass			
Boiler and Machinery			
Elevator			
Animal			
Collision – Automobile			
Collision – Other			
Personal Injury Liability – Automobile			
Personal Injury Liability – Other			
Property Damage Liability – Automobile			
Property Damage Liability - Other			
Workers' Compensation and Employer's Liability			
Fidelity and Surety			
Credit			
Title			
Motor Vehicle and Aircraft – Property Damage			
Motor Vehicle and Aircraft – Fire			
Motor Vehicle and Aircraft – Theft			
Motor Vehicle and Aircraft – Comprehensive			
Motor Vehicle and Aircraft – Collision			
Marine Protection and Indemnity			
Aircraft Voluntary Settlement			
Hole-in-One			
Other			
Mortgage Guaranty			

NORTH DAKOTA	Authorized to Transact	Currently Transacting	Applying for
Life & Annuity			
Accident & Health			
Property			
Casualty			
Variable Life and Annuity			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

OHIO	Authorized to Transact	Currently Transacting	Applying for
Life Companies (O.R.C. 3911.01)			
Life			
Accident and Health (Including Disability)			
Annuities			
Variable Authority (if licensed under O.R.C. 3911.01 for both Life and Annuities lines of business, such company may apply for Variable Annuity) (O.R.C. 3911.011)			
Property & Casualty (O.R.C. 3929.01(A))			
(1) Fire			
(2) Allied Lines			
(3) Farmowners Multiple Peril			
(4) Homeowners Multiple Peril			
(5) Commercial Multiple Peril			
(6) Ocean Marine			
(7) Inland Marine			
(8) Financial Guarantee			
(9) Medical Malpractice			
(10) Earthquake			
(11) Group A&H			
(12) Credit A&H (Group and Individual)			
(13a) Collectively Renewable A&H			
(13b) Noncancellable A&H			
(13c) Guaranteed Renewable A&H			
(13d) Nonrenewable for Stated Reasons Only			
(13e) Other Accident Only			
(13f) All Other A&H			
(14) Workers' Compensation (to the extent permitted by law)			
(15) Other Liability			
(16a) Private Passenger Auto No-Fault (personal injury protection to the extent permitted by law)			
(16b) Other Private Passenger Auto Liability			
(16c) Commercial Auto No-Fault (personal injury protection to the extent permitted by law)			
(16d) Other Commercial Auto Liability			
(17a) Private Passenger Auto Physical Damage			
(17b) Commercial Auto Physical Damage			
(18) Aircraft (all perils)			
(19) Fidelity			
(20) Surety			
(21) Glass			
(22) Burglary and Theft			
(23) Boiler and Machinery			
(24) Credit			
(25) Reinsurance Only			
(26) Other (list)			
Title Insurance (O.R.C. 3953)			

OKLAHOMA	Authorized to Transact	Currently Transacting	Applying for
Life (O.S. 36 §702)			
Surety (including bail) (OAC 365:25-5-41)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

OKLAHOMA (continued)	Authorized to Transact	Currently Transacting	Applying for
Surety (excluding bail) (O.S. 36 §708)			
Title (O.S. 36 §709)			
Marine (O.S. 36 §705)			
Accident & Health (O.S. 36 §703)			
Property (O.S. 36 §704)			
Vehicle (O.S. 36 §706)			
Casualty (vehicle only) (O.S. 36 §706)			
Casualty (including vehicle)(O.S. 36 §707)			
Workers' Compensation (O.S. 36 §608, §612.2)			
Variable Annuity (O.S. 36 §6061, §6062, OAC 365:10.9.10)			
Variable Life (O.S. 36 §6061, §6062)			
Reinsurance (O.S. 36 §2132)			
Health Maintenance Organizations (O.S.36 §6901)			

OREGON	Authorized to Transact	Currently Transacting	Applying for
Life (ORS 731.170)			
Credit Life and Credit Health (ORS 743.371)			
Industrial Life Insurance (ORS 731.166)			
Health (ORS 731.162)			
Health Care Service Contractor (ORS 750.005)			
Health Care Service Contractor (Complementary Health Services) (ORS 750.005)			
Property (ORS 731.182)			
Casualty, Excluding Workers' Comp (ORS 731.158)			
Casualty, Including Workers' Comp (ORS 731.158)			
Marine & Transportation (ORS 731.174)			
Surety (ORS 731.186)			
Home Protection (only) (ORS 731.164)			
Mortgage (only) (ORS 731.178)			
Title (only) (ORS 731.190)			

PENNSYLVANIA	Authorized to Transact	Currently Transacting	Applying for
(Notes 1 and 2)			
Life			
Life and Annuities (40 P.S. § 382(a)(1))			
Separate Account – Variable Life (40 P.S. § 382 (a)(1))			
Separate Account – Variable Annuities (40 P.S. § 382 (a)(1))			
Accident and Health (40 P.S. § 382(a)(2))			
Property			
Fire and Allied Lines (40 P.S. § 382(b)(1))			
Inland Marine & Auto Physical (40 P.S. § 382(b)(2))			
Ocean Marine (40 P.S. § 382(b)(3))			
Casualty			
Fidelity and Surety (40 P.S. § 382(c)(1))			
Accident and Health (40 P.S. § 382(c)(2))			
Glass (40 P.S. § 382 (c)(3))			
Other Liability (40 P.S. § 382 (c)(4))			
Steam Boiler & Machinery (40 P.S. § 382 (c)(5))			
Burglary-Theft (40 P.S. § 382 (c)(6))			
Credit (40 P.S. § 382 (c)(7))			
Water (40 P.S. § 382 (c)(8))			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

PENNSYLVANIA (continued)	Authorized to Transact	Currently Transacting	Applying for
Elevator (40 P.S. § 382 (c)(9))			
Livestock (40 P.S. § 382 (c)(10))			
Auto Liability (40 P.S. § 382 (c)(11))			
Mine & Machinery (40 P.S. § 382 (c)(12))			
Personal Property Floater (40 P.S. § 382 (c)(13))			
Workers' Compensation (40 P.S. § 382 (c)(14)) (Note 3)			
Other (40 P.S. § 382 (e))			
Title (40 P.S. § 910-1)			

Note 1: A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

Note 2: The company must have transacted business for a minimum of one (1) year prior to seeking admission. If the company was recently acquired, at least one (1) year of operating experience under the new management is required. An affiliated insurer admitted in Pennsylvania and operating under the same ownership/management team for at least one year may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.

Note 3: The Department of Labor and Industry requires all insurers that are applying to write workers' compensation to complete and file an Initial Report of Accident and Illness Prevention Services. The Insurance Department will not issue a Certificate of Authority to an insurer to write workers' compensation insurance until the Department of Labor and Industry has indicated the company has made the necessary filing as required by the Workers' Compensation Act. The necessary form with instructions can be obtained at: http://www.insurance.pa.gov/Companies/DoingBusiness/Documents/LIBC_211I.pdf.

PUERTO RICO	Authorized to Transact	Currently Transacting	Applying for
Agricultural (Section 4.060 of the Insurance Code)			
Casualty (Section 4.080 of the Insurance Code)			
Disability (Section 4.030 of the Insurance Code)			
Fraternal Life (Chapter 36 of the Insurance Code)			
Health (Chapter 19 of the Insurance Code)			
Life (Section 4.020 of the Insurance Code)			
Marine & Transportation (Section 4.050 of the Insurance Code)			
Mortgage Loans (Chapter 23 of the Insurance Code)			
Title (Section 4.100 of the Insurance Code)			
Surety (Section 4.090 of the Insurance Code)			
Property (Section 4.040 of the Insurance Code)			
Variable Life (Section 4.020 of the Insurance Code)			
Variable Annuities (Section 4.020 of the Insurance Code)			
Vehicle (Section 4.070 of the Insurance Code)			

RHODE ISLAND	Authorized to Transact	Currently Transacting	Applying for
Life and Health Companies:			
Life (Note 1)			
Accident and Health (Note 1)			
Annuities (Note 1)			
Variable Life (Note 1)			
Variable Annuity (Note 1)			
Variable Contracts (Notes 1 and 2)			
Property and Casualty Companies: (Note 3)			
Fire			
Allied Lines			
Multi-Peril Crop			
Federal Flood			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

RHODE ISLAND (continued)	Authorized to Transact	Currently Transacting	Applying for
Farmowners Multi-Peril			
Homeowners Multi-Peril			
Commercial Multi-Peril			
Ocean Marine			
Inland Marine			
Medical Malpractice/Medical Liability			
Earthquake			
Accident & Health			
Workers' Compensation			
Other Liability			
Products Liability			
Automobile (Full Coverage)			
Aircraft (All Perils)			
Fidelity			
Surety			
Glass			
Burglary and Theft			
Boiler and Machinery			
Credit			
Warranty			
Title			
Financial Guaranty or Mortgage Guaranty			

A company will be granted authority for a line of business in Rhode Island only on the condition that the company already has authority to sell that line in its state of domicile.

Note 1: Includes individual and group, and credit and non-credit.

Note 2: Variable Contracts includes Variable Life and Variable Annuity.

Note 3: Or alternatively: All lines except Life, Annuities, Title, Mortgage Guaranty and Financial Guaranty.

SOUTH CAROLINA	Authorized to Transact	Currently Transacting	Applying for
Life and Annuities (SC 38-5-30)			
Accident and Health (SC 38-5-30)			
Property (SC 38-5-30)			
Casualty (SC 38-5-30)			
Surety (SC 38-5-30)			
Marine (SC 38-5-30)			
Title (SC 38-5-30)			

SOUTH DAKOTA	Authorized to Transact	Currently Transacting	Applying for
(1) Life			
(2) Health			
(3) Fire & Allied Lines			
(4) Inland & Ocean Marine			
(5) Workers' Compensation			
(6) Bodily Injury (No Auto)			
(7) Property Damage (No Auto)			
(8) Bodily Injury (Auto)			
(9) Property Damage (Auto)			
(10) Physical Damage (Auto)			
(11) Fidelity & Surety Bonds			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

SOUTH DAKOTA (continued)	Authorized to Transact	Currently Transacting	Applying for
(12) Glass			
(13) Burglary & Theft			
(14) Boiler & Machinery			
(15) Aircraft			
(16) Credit (includes Credit Life; Credit Health; Credit Mortgage Guaranty and GAP (Guaranteed Auto Protection))			
(17) Crop - Hail			
(18) Livestock			
(19) Title			
(20) Variable Annuity			
(21) Variable Life			
(22) Reinsurance			
(23-A) Travel			
(23-C) Bail Bonds			
(24) SD Farm Mutual (County)			
(25) SD Farm Mutual (State)			
(27) Personal			

TENNESSEE	Authorized to Transact	Currently Transacting	Applying for
Life (TCA 56-2-201), (a)			
Accident and Health (TCA 56-2-201), (a)			
Credit (TCA 56-2-201), (a)			
Variable Contracts (TCA 56-2-201), (a)			
Property (TCA 56-2-201), (a), (b)			
Vehicle (TCA 56-2-201), (a), (c)			
Casualty (TCA 56-2-201) (a), (d)			
Surety (TCA 56-2-201) (a), (e)			
Title (TCA 56-35-112) (a)			

- (a) Company may only write lines in Tennessee that they are authorized to write in their domiciliary state.
- (b) Includes Fire and Extended Coverage, Other Allied Lines, Homeowners Multiple Peril, Commercial Multiple Peril, Earthquake, Growing Crops, Water Damage – Sprinkler Leakage, Ocean Marine and Inland Marine.
- (c) Automobile Bodily Injury, Automobile Property Damage and Automobile Physical Damage. (The Vehicle class is to be used when the company requests Vehicle only and no other Casualty line)
- (d) All lines listed under (c) above in addition to Disability, General Liability, Workers' Compensation, Burglary and Theft, Personal Property Floater, Glass, Boiler, Water Damage, Credit, Elevator, Livestock, Collision, Malpractice, Miscellaneous.
- (e) Credit, Accident and Health, Fidelity, Performance Contracts and Bonds, Indemnification Insurance and Mortgage Guaranty.

TEXAS	Authorized to Transact	Currently Transacting	Applying for
Fire			
Allied Coverages (a)			
Hail, growing crops only			
Rain			
Inland Marine (b)			
Ocean Marine			
Aircraft Liability			
Aircraft Physical Damage			
Accident			
Health			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

TEXAS (continued)	Authorized to Transact	Currently Transacting	Applying for
Workers' Comp & Emp. Liability			
Employer's Liability			
Automobile Liability (c)			
Automobile Physical Damage (d)			
Liability other than Automobile (e)			
Fidelity and Surety			
Glass			
Burglary and Theft			
Forgery			
Boiler and Machinery			
Credit (f)			
Livestock (g)			
Title (h)			
Mortgage Guaranty Type I (i)			
Mortgage Guaranty Type II (i)			
Life (includes Annuity)			
Variable Life			
Variable Annuity			

When one of the above coverages includes more than one kind or sub-line of insurance, the selection of that coverage authorizes the company to write one or more of the specified kinds of insurance included in that coverage.

- (a) Includes, but not limited to, Extended Coverage, Windstorm, Lightning, Hurricane, Hail (except growing crops), Explosion, Riot, Civil Commotion, Smoke, Aircraft, Land Vehicles, Physical Loss Form, Additional Extended Coverage, Vandalism, Malicious Misc
- (b) Includes Personal Property Floater.
- (c) Includes Bodily Injury, Medical Payments, Property Damage, and other Automobile Liability.
- (d) Includes Fire, Theft, Collision, Comprehensive and other Automobile Physical Damage.
- (e) Includes Bodily Injury, Medical Payments and Property Damage with regards to Comprehensive Personal Liability, Owners, Landlords and Tenants, Manufacturers and Contractors, Product, Contractual, Elevator (including Elevator Collision), Employers' Liability, Professional Liability for Physicians, Podiatrists, Certified Anesthetists, and Hospitals, and other Liability other than Automobile.
- (f) Includes Credit Involuntary Unemployment; excludes Mortgage Guaranty.
- (g) Mortality.
- (h) May be written only by Title insurance companies except those companies transacting title insurance prior to October 1, 1967. Includes Attorney's Title insurance companies as authorized by Texas Insurance Code, Chapter 2551.
- (i) May be written only by Mortgage Guaranty insurance companies as authorized by Texas Insurance Code, Chapter 3502.

UTAH	Authorized to Transact	Currently Transacting	Applying for
Health			
Health Maintenance Organization (Utah Code Ann. §31A-8-101(5))			
Limited Health Plan (Utah Code Ann. §31A-8-101(3)(a))			
Limited Health Plan – Dental			
Limited Health Plan – Vision			
Nonprofit Health Plan (Utah Code Ann. §31A-7-102)			
Life			
Life Insurance, including annuity and variable products (Utah Code Ann. §31A-1-301(110), 31A-1-301(9) & 31A-20-106)			
Property and Casualty			
Accident & Health (Utah Code Ann. §31A-1-301(1)(a))			
Bail Bond Surety (Utah Code Ann. § 31A-1-301(12))			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

UTAH (continued)	Authorized to Transact	Currently Transacting	Applying for
Credit Guarantee (Utah Code Ann. § 31A-1-301(37)(a))			
Legal Expense (Utah Code Ann. § 31A-1-301(107)(a))			
Liability Insurance (Utah Code Ann. § 31A-1-301(108)(a))			
Marine & Transportation (Utah Code Ann. § 31A-1-301(90) & 31A-1-301 (130))			
Motor Club (Utah Code Ann. § 31A-1-301(125))			
Professional Liability, excluding medical malpractice (Utah Code Ann. § 31A-1-301(108))			
Professional Liability, including medical malpractice (Utah Code Ann. § 31A-1-301(119) & 31A-1-301(151))			
Property Insurance (Utah Code Ann. § 31A-1-301(152)(a)(b))			
Surety Insurance (Utah Code Ann. § 31A-1-301(177))			
Title Insurance (Utah Code Ann. § 31A-1-301(180))			
Vehicle Liability Insurance (Utah Code Ann. § 31A-1-301(185))			
Workers' Compensation Insurance (Utah Code Ann. § 31A-1-301(188))			

VERMONT	Authorized to Transact	Currently Transacting	Applying for
Life (Section 3301(a)(1))			
Variable Annuity (Section 3301(a)(1)) and (Section 3857)			
Variable Life (Section 3301(a)(1)) and (Section 3857)			
Health (Section 3301(a)(2))			
Casualty (Section 3301(a)(3))			
Marine and Transportation (Section 3301(a)(4))			
Marine Protection and Indemnity (Section 3301(a)(5))			
Wet Marine and Transportation (Section 3301(a)(6))			
Property (Section 3301(a)(7))			
Surety (Section 3301(a)(8))			
Title (Section 3301(a)(9))			
Multiple Line (Section 3301(a)(10))			

VIRGINIA	Authorized to Transact	Currently Transacting	Applying for
(§ 38.2 101 through 134)			
Life and Health and Fraternal Benefit Society			
01 Life			
02 Industrial Life			
03 Credit Life			
04 Variable Life			
05 Annuities			
06 Variable Annuities			
07 Accident and Sickness			
08 Credit Accident and Sickness			
99 Managed Care Health Insurance Plan *			
Title			
33 Title			
Property and Casualty			
07 Accident and Sickness			
08 Credit Accident and Sickness			
09 Fire			
10 Miscellaneous Property and Casualty			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

VIRGINIA (continued)	Authorized to Transact	Currently Transacting	Applying for
11 Farmowners Multi Peril			
12 Homeowners Multi Peril			
13 Commercial Multi Peril			
14 Ocean Marine			
15 Inland Marine			
16 Workers' Comp-Emp Liability			
17 Liability Other Than Auto			
18 Auto Liability			
19 Auto Physical Damage			
20 Aircraft Liability			
21 Aircraft Physical Damage			
23 Fidelity			
24 Surety			
25 Glass			
26 Burglary and Theft			
27 Boiler and Machinery			
28 Credit			
29 Animal			
30 Water Damage			
32 Legal Services			
55 Home Protection			
56 Mortgage Guaranty			
74 Credit Involuntary Unemployment			
75 Credit Property			
99 Managed Care Health Insurance Plan *			

* Companies applying to operate a Managed Care Health Insurance Plan (MCHIP) will be required to obtain a Certificate of Quality Assurance (Certificate) from the Virginia Department of Health pursuant to § 38.2-5800 et seq. of the Code of Virginia. Upon receipt of an application to operate an MCHIP, the Bureau of Insurance will send a letter to the applicant describing the requirements for operating an MCHIP that includes the requirement to obtain a Certificate of Quality Assurance from the Virginia Department of Health.

WASHINGTON	Authorized to Transact	Currently Transacting	Applying for
Life (RCW 48.11.020)			
Disability (RCW 48.11.030)			
Health (RCW 48.11.030)			
Health Maintenance Organization (RCW 48.46)			
Health Care Service Contractor (RCW 48.44)			
Limited Health Care Service Contractor (RCW 48.44)			
Property (RCW 48.11.040)			
Marine and Transportation (RCW 48.11.050)			
Vehicle (RCW 48.11.060)			
General Casualty (RCW 48.11.070)			
Surety (RCW 48.11.080)			
Title (RCW 48.11.100)			
Ocean Marine (RCW 48.11.105)			

WEST VIRGINIA	Authorized to Transact	Currently Transacting	Applying for
Life (WV Code §33-1-10(a))			
Accident & Sickness (WV Code §33-1-10(b))			
Fire (WV Code §33-1-10(c))			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

WEST VIRGINIA (continued)	Authorized to Transact	Currently Transacting	Applying for
Marine (WV Code §33-1-10(d))			
Casualty without Workers' Compensation (WV Code §33-1-10(e))			
Casualty with Workers' Compensation (WV Code §33-1-10(e)(14))			
Surety (WV Code §33-1-10(f)(1)) Fidelity			
Surety (WV Code §33-1-10(f)(2)) Performance			
Surety (WV Code §33-1-10(f)(3)) Financial Guaranty			
Surety (WV Code §33-1-10(f)(3)) Mortgage Guaranty (monoline)			
Surety (WV Code §33-1-10(f)(4)) Title			
Reinsurance (WV Code §33-1-11)*			
Variable Annuity (WV Code §33-13A)			
Variable Life (WV Code §33-13A)			
Physicians' Mutual (WV Code §33-20F)			
Reciprocal (WV Code §33-21) **			
Farmers Mutual Fire (WV Code §33-22)			
Fraternal (WV Code §33-23)			
Hospital Service Corporation (WV Code §33-24)			
Medical Service Corporation (WV §33-24)			
Health Service Corporation (WV §33-24)			
Dental Service Corporation (WV §33-24)			

* Indicate above the kinds of insurance to be reinsured, if application is for authority to transact reinsurance only.

** Indicate above the kinds of insurance to be written by the reciprocal insurer

WISCONSIN	Authorized to Transact	Currently Transacting	Applying for
(s. Ins 6.75, Wis. Adm. Code)			
(1) (a) Life and Insurance Annuities - Nonparticipating			
(1) (a) Life and Insurance Annuities -Participating			
(1) (b) Variable Life and Variable Annuities			
(1) (c) Disability (includes health)			
(2) (a) Fire, Inland Marine and Other Property			
(2) (b) Ocean Marine			
(2) (c) Disability (includes health)			
(2) (d) Liability and Incidental Medical Expense			
(2) (e) Automobile			
(2) (f) Fidelity Insurance			
(2) (g) Surety Insurance			
(2) (h) Title			
(2) (i) Mortgage Guaranty			
(2) (j) Credit Insurance			
(2) (k) Workers' Compensation Insurance			
(2) (l) Legal Expense Insurance			
(2) (m) Credit Unemployment Insurance			
(2) (n) Miscellaneous			
(2) (o) Aircraft			

WYOMING	Authorized to Transact	Currently Transacting	Applying for
Life, including annuities (WS 26-5-102)			
Variable Contracts (WS 26-5-102)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

WYOMING (continued)	Authorized to Transact	Currently Transacting	Applying for
Disability (WS 26-5-103)			
Property (WS 26-5-104)			
Surety (WS 26-5-105)			
Casualty (WS 26-5-106)			
Marine and Transportation (WS 26-5-107)			
Multiple Lines (WS 26-5-108)			
Title (WS 26-5-109)			

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: Form A UCAA Type: UCAA Type Other: Other

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Applicant Company Name

Address: Applicant Company Address

City: Applicant Company City

State/Province: State/Province

Postal Code: Postal Code

Phone: Phone

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name

2. a. Are you a citizen of the United States?

☐ Yes ☐ No

b. Are you a citizen of any other country?

☐ Yes ☐ No

If yes, what country? If yes, what country?

3. Affiant's occupation or profession: Affiant's occupation or profession

4. Affiant's business address: Affiant's business address

Business telephone: Business telephone

Business email: Business email

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>College/University (C/U)</u>	<u>C/U City/State</u>	<u>MM/YY-MM/YY</u>	<u>Degree Obtained</u>

<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Graduate Studies (GS)</u>	<u>GS College/University</u>	<u>GS City/State</u>	<u>MM/YY-MM/YY</u>	<u>GS Degree Obtained</u>

<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

<u>Other Training: Name (OT)</u>	<u>OT City/State</u>	<u>MM/YY-MM/YY</u>	<u>OT Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>

7. Present or proposed position with the Applicant Company: Present or proposed position with the Applicant Company

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

9. a. Have you ever been in a position which required a fidelity bond?

☐ Yes ☐ No

If any claims were made on the bond, give details: Give Details

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

☐ Yes ☐ No

If yes, give details: Give Details

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Question 10, Give Details

Organization/Issuer of License: Org/Issuer License

Address: Address

City: City

State/Province: State/Province

Country: Country

Postal Code: Postal Code

License Type: License Type

License #: License #

Date Issued (MM/YY): MM/YY

Date Expired (MM/YY): MM/YY

Reason for Termination: Reason for Termination

Non-Insurance Regulatory Phone Number (if known): Phone Number

Organization/Issuer of License: Org/Issuer License

Address: Address

City: City

State/Province: State/Province

Country: Country

Postal Code: Postal Code

License Type: License Type

License #: License #

Date Issued (MM/YY): MM/YY

Date Expired (MM/YY): MM/YY

Reason for Termination: Reason for Termination

Non-Insurance Regulatory Phone Number (if known): Phone Number

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

☐ Yes ☐ No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

☐ Yes ☐ No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

☐ Yes ☐ No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

☐ Yes ☐ No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

☐ Yes ☐ No

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

If yes, provide details including dates, locations, dispositions, etc.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

List any entity subject to regulation by an insurance regulatory authority that control directly or indirectly.

If any of the stock is pledged or hypothecated in any way, give details. Give details if stock is pledged or hypothecated.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

☐ Yes ☐ No

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

Provide Details.

If any of the shares of stock are pledged or hypothecated in any way, give details.

If shares are pledged or hypothecated, give details.

14. Have you ever been adjudged a bankrupt?

☐ Yes ☐ No

If yes, provide details: If yes, provide details.

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. Group Code(s).

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

☐ Yes ☐ No

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

☐ Yes ☐ No

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

If the answer to any of the above is yes, please indicate and give details.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Dated and signed this Day day of Month 20Year at Click or tap here to enter text.. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

 I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification..

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: Form A UCAA Type: UCAA Type Other: Other

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Applicant Company Name

Address: Applicant Company Address

City: Applicant Company City

State/Province: State/Province

Postal Code: Postal Code

Phone: Phone

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name
IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS
COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

☐ Yes ☐ No

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: XXX-XX-XXXX.

4. Government Identification Number if not a U.S. Citizen:

Government ID Number:

Govt. ID Number

Govt. ID Number

Govt. ID Number

Country of Issuance:

Country of Issuance

Country of Issuance

Country of Issuance

5. Foreign Student ID# (if applicable): Foreign Student ID Number

6. Date of Birth: (MM/DD/YY): MM/DD/YY

State/Province: State/Province

Place of Birth, City: Place of Birth, City

Country: Country

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

7. Name of Affiant's Spouse (if applicable): Name of Affiant's Spouse

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this Day day of Month, 20Year at Click or tap here to enter text.. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

 I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:
Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with a pending application of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through Name of CRA and Address. [name of CRA, address] ("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

My Commission Expires

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL - INDIVIDUAL

I, _____, the undersigned, do not and will not exercise or attempt to exercise any influence or control, either directly or indirectly, over the business operations, affairs, or activities of _____ ("company"), or any entity owned or controlled by the company and licensed by the Florida Office of Insurance Regulation ("Office"), without the advance written consent of the Office.

I understand that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Witnessed By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL - ENTITY

I, _____, the undersigned, representing _____, certify that other than the individuals listed on the attached register, no person in this entity does or will exercise or attempt to exercise any influence or control, either directly or indirectly, over the business operations, affairs, or activities of _____ ("company"), or any entity owned or controlled by the company and licensed by the Florida Office of Insurance Regulation ("Office"), without the advance written consent of the Office.

I understand that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Witnessed By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL AFFIDAVIT – ENTITY

REGISTER

Below is a complete list of individuals associated with _____
who do or will exercise or attempt to exercise influence or control, either directly or
indirectly, over the business operations, affairs, or activities of the company, or any entity
owned or controlled by the company and licensed by the Office. Date: _____

Name (Typed or Printed)

Position

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

*Additional pages in the same format may be attached as needed.

OIR-C1-1468

Rev: 7/21

Rule 69O-136.100

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Uniform Consent to Service of Process

_____ Original Designation

_____ Amended Designation

(must be submitted directly to states)

Applicant Company Name: _____

Previous Name (if applicable): _____

Statutory Home Office Address: _____

City, State, Zip: _____ NAIC CoCode: _____

The Applicant Company named above, organized under the laws of _____, and regulated under the laws of _____ for purposes of complying with the laws of the State(s) designate hereunder relating to the holding of a certificate of authority or the conduct of an insurance business within said State(s), pursuant to a resolution adopted by its board of directors or other governing body, hereby irrevocably appoints the officers of the State(s) and their successors identified in Exhibit A, or where applicable appoints the required agent so designated in Exhibit A hereunder as its attorney in such State(s) upon whom may be served any notice, process or pleading as required by law as reflected on Exhibit A in any action or proceeding against it in the State(s) so designated; and does hereby consent that any lawful action or proceeding against it may be commenced in any court of competent jurisdiction and proper venue within the State(s) so designated; and agrees that any lawful process against it which is served under this appointment shall be of the same legal force and validity as if served on the entity directly. This appointment shall be binding upon any successor to the above named entity that acquires the entity's assets or assumes its liabilities by merger, consolidation or otherwise; and shall be binding as long as there is a contract in force or liability of the entity outstanding in the State. The entity hereby waives all claims of error by reason of such service. The entity named above agrees to submit an amended designation form upon a change in any of the information provided on this power of attorney.

Applicant Company Officers' Certification and Attestation

One of the two Officers (listed below) of the Applicant Company must read the following very carefully and sign:

1. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant Company.
2. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at _____.

Date

Signature of President

Full Legal Name of President

Date

Signature of Secretary

Full Legal Name of Secretary

Uniform Certificate of Authority (UCAA)
Uniform Consent to Service of Process
Exhibit A

Place an "X" before the names of all the States for which the person executing this form is appointing the designated agent in that State for receipt of service of process:

☐ AL	Commissioner of Insurance # and Resident Agent*	☐ MO	Director of Insurance #
☐ AK	Director of Insurance #	☐ MT	Resident Agent*
☐ AZ	Director of Insurance # ^	☐ NE	Officer of Company* or Resident Agent* (circle one)
☐ AR	Resident Agent *	☐ NH	Commissioner of Insurance #
☐ AS	Commissioner of Insurance #	☐ NV	Commissioner of Insurance Commission # ^
☐ CO	Commissioner of Insurance # or Resident Agent*	☐ NJ	Commissioner of Banking and Insurance #^
☐ CT	Commissioner of Insurance #	☐ NM	Superintendent of Insurance #
☐ DE	Commissioner of Insurance #	☐ NY	Superintendent of Financial Services #
☐ DC	Commissioner of Insurance and Securities Regulation # or Local Agent* (circle one)	☐ NC	Commissioner of Insurance
☐ FL	Chief Financial Officer # ^	☐ ND	Commissioner of Insurance # ^
☐ GA	Commissioner of Insurance and Safety Fire # and Resident Agent*	☐ OH	Resident Agent*
☐ GU	Commissioner of Insurance #	☐ OR	Resident Agent*
☐ HI	Insurance Commissioner # and Resident Agent*	☐ OK	Commissioner of Insurance #
☐ ID	Director of Insurance # ^	☐ PR	Commissioner of Insurance #
☐ IL	Director of Insurance #	☐ RI	Superintendent of Insurance ^
☐ IN	Resident Agent* ^	☐ SC	Director of Insurance #
☐ IA	Commissioner of Insurance #	☐ SD	Director of Insurance # ^
☐ KS	Commissioner of Insurance ^	☐ TN	Commissioner of Insurance #
☐ KY	Secretary of State #	☐ TX	Resident Agent*
☐ LA	Secretary of State #	☐ UT	Resident Agent* ^
☐ MD	Insurance Commissioner #	☐ VT	Resident Agent*
☐ ME	Resident Agent* ^	☐ VI	Lieutenant Governor/Commissioner#
☐ MI	Resident Agent *	☐ WA	Insurance Commissioner #
☐ MN	Commissioner of Commerce ~	☐ WV	Secretary of State # @
☐ MS	Commissioner of Insurance and Resident Agent* BOTH are required.	☐ WY	Commissioner of Insurance #

For the forwarding of Service of Process received by a State Officer complete Exhibit B listing by state the entities (one per state) with **full name and address where service of process is to be forwarded**. Use additional pages as necessary. Colorado will forward Service of Process to the Secretary of the Applicant Company and requires a resident agent for foreign entities. Exhibit not required for New Jersey, and North Carolina. Florida accepts only an individual as the entity and requires an email address. New Jersey allows but does not require a foreign insurer to designate a specific forwarding address on Exhibit B. SC will not forward to an individual by name; however, it will forward to a position, e.g., Attention: President (or Compliance Officer, etc.). Washington requires an email address on Exhibit B.

* Attach a completed Exhibit B listing the Resident Agent for the Applicant Company (one per state). Include state name, Resident Agent's **full name and street address**. Use additional pages as necessary. (DC* requires an agent within a ten-mile radius of the District), (MT requires an agent to reside or maintain a business in MT).

^ Initial pleadings only.

@ Form accepted only as part of a Uniform Certificate of Authority application.

MA will send the required form to the Applicant Company when the approval process reaches that point.

~ Minnesota does not forward Service of Process. To effectively serve the Commissioner of Commerce, use the process under Minn. Stat. § 45.028. Applicant Company may complete Exhibit B to provide a Service of Process address that Commerce may keep on file.

Exhibit A

Uniform Certificate of Authority (UCAA)
Uniform Consent to Service of Process
Exhibit B

Complete for each state indicated in Exhibit A:

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

Exhibit B

Resolution Authorizing Appointment of Attorney

BE IT RESOLVED by the Board of Directors or other governing body of

(Applicant Company Name)

this _____ day of _____, 20____, that the President or Secretary of said entity be and are hereby authorized by the Board of Directors and directed to sign and execute the Uniform Consent to Service of Process to give irrevocable consent that actions may be commenced against said entity in the proper court of any jurisdiction in the state(s) of

in which the action shall arise, or in which plaintiff may reside, by service of process in the state(s) indicated above and irrevocably appoints the officer(s) of the state(s) and their successors in such offices or appoints the agent(s) so designated in the Uniform Consent to Service of Process and stipulate and agree that such service of process shall be taken and held in all courts to be as valid and binding as if due service had been made upon said entity according to the laws of said state.

CERTIFICATION:

I, _____, Secretary of

(Applicant Company Name)

state that this is a true and accurate copy of the resolution adopted effective the ____ day of _____, 20____ by the Board of Directors or governing board at a meeting held on the _____ day of _____, 20____ or by written consent dated ____ day of _____, 20____.

Date _____

Secretary



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL - INVESTMENT COMPANIES

I, _____, the undersigned, on behalf of _____ (entity disclaiming control) represent that said entity holds the shares of _____ ("company"), solely for investment purposes, and does not and will not exercise or attempt to exercise any influence or control, either directly or indirectly, over the business operations, affairs, or activities of the company, or any other entity owned or controlled by the company and licensed by the Florida Office of Insurance Regulation ("Office"), without the advance written consent of the Office. I further represent that _____ (entity disclaiming control) does not have, and will not seek, influence or representation on the Board of Directors of the company, or equivalent organizational body.

I understand that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Witnessed By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

OIR-C1-2221

Rev: 6/20

Rule 690-136.100

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

By

Name of Registrant

On Behalf of Following Insurance Companies

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

Date: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name;
- (b) Home office address;
- (c) Principal executive office address;
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;
- (e) The principal business of the person;
- (f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and
- (g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

- (a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
- (b) Purchases, sales or exchanges of assets;
- (c) Transactions not in the ordinary course of business;
- (d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

- (e) All management agreements, service contracts and all cost-sharing arrangements;
- (f) Reinsurance agreements;
- (g) Dividends and other distributions to shareholders;
- (h) Consolidated tax allocation agreements; and
- (i) Any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 4 of the Act.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the registrant.

ITEM 6. EMPLOYMENT CONTRACTS

Furnish the following information with regard to each employment contract entered into by the insurer and each of its affiliates with any of the other officers and/or directors of the insurer: name of employees, position held, annual remuneration, and other perquisites, and term of contract.

ITEM 7. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

- (a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and
- (b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 8. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 9. FINANCIAL STATEMENTS AND EXHIBITS

- (a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.
- (b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

- (c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or regulation Sections 4 and 6.

ITEM 10. FORM C REQUIRED

A Form C, Summary of Changes to Registration Statement (OIR-A1-2116), must be prepared and filed with this Form B.

ITEM 11. SIGNATURE AND CERTIFICATION

I have reviewed the above, and to the best of my knowledge, information and belief, it is true and correct.

Date Name Position or Title

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20__, by _____
(name of person)
as _____ for _____
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

UCAA Proforma Financial Statements
Property and Casualty Insurance Company

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (the first full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.
7. For additional guidance, refer to the FAQ's on the UCAA webpage.

Enter the Applicant Company Name:

Applicant Company Name

Year 1:

Year 2:

Year 3:

1

2

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button



☐	AK	Alaska	☐	MT	Montana
☐	AL	Alabama	☐	NC	North Carolina
☐	AR	Arkansas	☐	ND	North Dakota
☐	AS	American Samoa	☐	NE	Nebraska
☐	AZ	Arizona	☐	NH	New Hampshire
☐	CA	California	☐	NJ	New Jersey
☐	CO	Colorado	☐	NM	New Mexico
☐	CT	Connecticut	☐	NV	Nevada
☐	DC	District Of Columbia	☐	NY	New York
☐	DE	Delaware	☐	OH	Ohio
☐	FL	Florida	☐	OK	Oklahoma
☐	GA	Georgia	☐	OR	Oregon
☐	GU	Guam	☐	PA	Pennsylvania
☐	HI	Hawaii	☐	PR	Puerto Rico
☐	IA	Iowa	☐	RI	Rhode Island
☐	ID	Idaho	☐	SC	South Carolina
☐	IL	Illinois	☐	SD	South Dakota
☐	IN	Indiana	☐	TN	Tennessee
☐	KS	Kansas	☐	TX	Texas
☐	KY	Kentucky	☐	UT	Utah
☐	LA	Louisiana	☐	VA	Virginia
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands
☐	MD	Maryland	☐	VT	Vermont
☐	ME	Maine	☐	WA	Washington
☐	MI	Michigan	☐	WI	Wisconsin
☐	MN	Minnesota	☐	WV	West Virginia
☐	MO	Missouri	☐	WY	Wyoming
☐	MS	Mississippi			

Applicant Company Name

FORM 13 Property/Casualty

Company Name:
(Property & Casualty Insurance Company)
Pro Forma Statutory Profit & Loss Statement
(In Whole Dollars)

Applicant Company Name

	0	1	2
1. Net Premiums Earned			
2. Net Losses Incurred (Case & IBNR)			
3. Net Loss Adjustment Expenses Incurred			
4. Direct and Assumed Commissions & Brokerage			
5. Reinsurance Ceding Commissions			
6. Net Commissions Incurred (4-5)	-	-	-
7. Other Contractual Agreements*			
8. Other Underwriting Expenses Incurred**			
9. Underwriting Gain (Loss) (1-(2+3+6+7+8))	-	-	-
10. Net Investment Income			
11. Other Income			
12. Income Taxes Incurred			
13. Net Operating Income (Loss) after taxes	-	-	-
14. Prior YE Surplus as Regards Policyholders, December 31 Prior Year			
15. Net Income	-	-	-
16. Capital Increases Changes			
17. Other Increases (Decreases)			
18. Dividends to Stockholders			
19. YE Surplus as Regards Policyholders, December 31 Current Year	-	-	-
Operating Percentages:			
Net Premiums Earned	100.00%	100.00%	100.00%
20. Net Losses Incurred to Net Premiums Earned(2/1)	0.00%	0.00%	0.00%
21. Net Loss Adjustment Expenses Incurred to Net Premiums Earned(3/1)	0.00%	0.00%	0.00%
22. Other Underwriting Expenses to Net Premiums Earned ((6+7+8)/1)	0.00%	0.00%	0.00%
23. Net Underwriting Gain Or (Loss) (9/1)	0.00%	0.00%	0.00%
Other Percentages:			
24. Other Underwriting Expenses to Net Premiums Written ((6+7+8)/Total Net Premiums Written))	0.00%	0.00%	0.00%
25. Net Loss and Loss Adjustment Expenses Incurred to Net Premiums Earned ((2+3)/1)	0.00%	0.00%	0.00%
*ie... MGA(excluding amounts included above as agents commissions), service contracts, claims payment contracts			
** Itemize in assumptions			

Company Name:
(Property & Casualty Insurance Company)
Pro Forma Statutory Cash Flow Statement
(In Whole Numbers)

Applicant Company Name

	0	1	2
Cash From Operations			
1. Premiums Collected Net of Reinsurance			
2. Net Investment Income			
3. Miscellaneous Income			
4. Benefit and Loss Related Payments			
5. Net Transfers to Separate Accounts, Segrated Accounts and Protected Cell Accounts			
6. Commissions, Expenses Paid and Aggregate Write-Ins for Deductions			
7. Dividends Paid to Policyholders			
8. Federal and Foreign Income Taxes Paid (Recovered)			
9. Net Cash From Operations (1+2+3-4-5-6-7-8)	-	-	-
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Miscellaneous Sources			
11. Surplus Notes, Capital Notes			
12. Capital and Paid in Surplus, Less Treasury Stock			
13. Borrowed Funds			
14. Net Deposits on Deposit-Type Contracts and Other Insurance Liabilities			
15. Dividends to Stockholders			
16. Other Cash Provided (Applied)			
17. Net Cash from Financing and Miscellaneous Sources (11+12+13+14-15+16)	-	-	-
18. Net Change in Cash, Cash Equivalents and Short -Term Investments (9+10+17)	-	-	-

Company Name:
(Property & Casualty Insurance Company)
Premiums Written to Surplus Ratios
Amounts in Whole Dollars

Applicant Company Name

Nationwide

Year	Direct Premiums Written	Assumed Premiums Written	Gross Premiums Written	Ceded Premiums Written	Net Premiums Written	Gross Written Premiums to Surplus	NetWritten Premiums to Surplus
0	-	-	-	-	-	-	-
1	-	-	-	-	-	-	-
2	-	-	-	-	-	-	-

No data entry is required on this page.

Applicant Company Name:
(Property & Casualty Insurance Company)
Nationwide Premium by LOB - Planned Premium Volume By Line of Business
Amounts in Whole Dollars

Applicant Company Name

The Nationwide Premium by LOB page is automatically calculated. It is calculated based on projected premiums by line of business for each state in which the company is already licensed and authorized to write business and projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums will pull from the Authorized Premium By LOB tab and individual state tabs.

Nationwide											
Year 1		0									
Annual		Direct Premiums	Assumed Premiums	Ceded Premiums		Direct Premiums	Assumed Premiums	Ceded Premiums			
Statement Line	Description	Written	Written	Written	Net Premiums Written	Earned	Earned	Earned	Earned	Net Premiums Earned	
1.0	Fire	-	-	-	-	-	-	-	-	-	-
2.1	Allied Lines	-	-	-	-	-	-	-	-	-	-
2.2	Multiple Peril Crop	-	-	-	-	-	-	-	-	-	-
2.3	Federal Flood	-	-	-	-	-	-	-	-	-	-
2.4	Private Crop	-	-	-	-	-	-	-	-	-	-
2.5	Private Flood	-	-	-	-	-	-	-	-	-	-
3.0	Farmowners Multiple Peril	-	-	-	-	-	-	-	-	-	-
4.0	Homeowners Multiple Peril	-	-	-	-	-	-	-	-	-	-
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-	-	-	-	-	-	-	-
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-	-	-	-	-	-	-	-
6.0	Mortgage Guaranty	-	-	-	-	-	-	-	-	-	-
8.0	Ocean Marine	-	-	-	-	-	-	-	-	-	-
9.0	Inland Marine	-	-	-	-	-	-	-	-	-	-
10.0	Financial Guaranty	-	-	-	-	-	-	-	-	-	-
11.0	Medical Professional Liability	-	-	-	-	-	-	-	-	-	-
12.0	Earthquake	-	-	-	-	-	-	-	-	-	-
13.0	Group Accident & Health	-	-	-	-	-	-	-	-	-	-
14.0	Credit A&H (Group & Individual)	-	-	-	-	-	-	-	-	-	-
15.1	Collectively Renewable A&H	-	-	-	-	-	-	-	-	-	-
15.2	Non-Cancellable A&H	-	-	-	-	-	-	-	-	-	-
15.3	Guaranteed Renewable A&H	-	-	-	-	-	-	-	-	-	-
15.4	Non-Renewable for Stated Reasons Only	-	-	-	-	-	-	-	-	-	-
15.5	Other Accident Only	-	-	-	-	-	-	-	-	-	-
15.6	Medicare Title XVIII Exempt From State Taxes or Fees	-	-	-	-	-	-	-	-	-	-
15.7	All Other A&H	-	-	-	-	-	-	-	-	-	-
15.8	Federal Employees Health Benefits Plan Premium	-	-	-	-	-	-	-	-	-	-
16.0	Workers' Compensation	-	-	-	-	-	-	-	-	-	-
17.1	Other Liability—Occurrence	-	-	-	-	-	-	-	-	-	-
17.2	Other Liability—Claims Made	-	-	-	-	-	-	-	-	-	-
17.3	Excess Workers' Compensation	-	-	-	-	-	-	-	-	-	-
18.0	Products Liability	-	-	-	-	-	-	-	-	-	-
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-	-	-	-	-	-	-	-
19.2	Other Private Passenger Auto Liability	-	-	-	-	-	-	-	-	-	-
19.3	Commercial Auto No-Fault (PIP)	-	-	-	-	-	-	-	-	-	-
19.4	Other Commercial Auto Liability	-	-	-	-	-	-	-	-	-	-
21.1	Private Passenger Auto Physical Damage	-	-	-	-	-	-	-	-	-	-
21.2	Commercial Auto Physical Damage	-	-	-	-	-	-	-	-	-	-
22.0	Aircraft (All Perils)	-	-	-	-	-	-	-	-	-	-
23.0	Fidelity	-	-	-	-	-	-	-	-	-	-
24.0	Surety	-	-	-	-	-	-	-	-	-	-
26.0	Burglary and Theft	-	-	-	-	-	-	-	-	-	-
27.0	Boiler and Machinery	-	-	-	-	-	-	-	-	-	-
28.0	Credit	-	-	-	-	-	-	-	-	-	-
30.0	Warranty	-	-	-	-	-	-	-	-	-	-
34.0	Prepaid Legal	-	-	-	-	-	-	-	-	-	-
34.0	Bail Bonds	-	-	-	-	-	-	-	-	-	-
34.0	Glass	-	-	-	-	-	-	-	-	-	-
34.0	Title	-	-	-	-	-	-	-	-	-	-
34.0	Livestock	-	-	-	-	-	-	-	-	-	-
34.0	Industrial Extended Coverage	-	-	-	-	-	-	-	-	-	-
34.0	Mobile Home Multiple Peril	-	-	-	-	-	-	-	-	-	-
34.0	Mobile Home Physical Damage	-	-	-	-	-	-	-	-	-	-
34.0	Reinsurance	-	-	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-	-	-
Total		-	-	-	-	-	-	-	-	-	-

Nationwide

Year 2 1

Annual Statement Line	Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
1.0	Fire	-	-	-	-	-	-	-	-
2.1	Allied Lines	-	-	-	-	-	-	-	-
2.2	Multiple Peril Crop	-	-	-	-	-	-	-	-
2.3	Federal Flood	-	-	-	-	-	-	-	-
2.4	Private Crop	-	-	-	-	-	-	-	-
2.5	Private Flood	-	-	-	-	-	-	-	-
3.0	Farmowners Multiple Peril	-	-	-	-	-	-	-	-
4.0	Homeowners Multiple Peril	-	-	-	-	-	-	-	-
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-	-	-	-	-	-
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-	-	-	-	-	-
6.0	Mortgage Guaranty	-	-	-	-	-	-	-	-
8.0	Ocean Marine	-	-	-	-	-	-	-	-
9.0	Inland Marine	-	-	-	-	-	-	-	-
10.0	Financial Guaranty	-	-	-	-	-	-	-	-
11.0	Medical Professional Liability	-	-	-	-	-	-	-	-
12.0	Earthquake	-	-	-	-	-	-	-	-
13.0	Group Accident & Health	-	-	-	-	-	-	-	-
14.0	Credit A&H (Group & Individual)	-	-	-	-	-	-	-	-
15.1	Collectively Renewable A&H	-	-	-	-	-	-	-	-
15.2	Non-Cancellable A&H	-	-	-	-	-	-	-	-
15.3	Guaranteed Renewable A&H	-	-	-	-	-	-	-	-
15.4	Non-Renewable for Stated Reasons Only	-	-	-	-	-	-	-	-
15.5	Other Accident Only	-	-	-	-	-	-	-	-
15.6	Medicare Title XVIII Exempt From State Taxes or Fees	-	-	-	-	-	-	-	-
15.7	All Other A&H	-	-	-	-	-	-	-	-
15.8	Federal Employees Health Benefits Plan Premium	-	-	-	-	-	-	-	-
16.0	Workers' Compensation	-	-	-	-	-	-	-	-
17.1	Other Liability—Occurrence	-	-	-	-	-	-	-	-
17.2	Other Liability—Claims Made	-	-	-	-	-	-	-	-
17.3	Excess Workers' Compensation	-	-	-	-	-	-	-	-
18.0	Products Liability	-	-	-	-	-	-	-	-
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-	-	-	-	-	-
19.2	Other Private Passenger Auto Liability	-	-	-	-	-	-	-	-
19.3	Commercial Auto No-Fault (PIP)	-	-	-	-	-	-	-	-
19.4	Other Commercial Auto Liability	-	-	-	-	-	-	-	-
21.1	Private Passenger Auto Physical Damage	-	-	-	-	-	-	-	-
21.2	Commercial Auto Physical Damage	-	-	-	-	-	-	-	-
22.0	Aircraft (All Perils)	-	-	-	-	-	-	-	-
23.0	Fidelity	-	-	-	-	-	-	-	-
24.0	Surety	-	-	-	-	-	-	-	-
26.0	Burglary and Theft	-	-	-	-	-	-	-	-
27.0	Boiler and Machinery	-	-	-	-	-	-	-	-
28.0	Credit	-	-	-	-	-	-	-	-
30.0	Warranty	-	-	-	-	-	-	-	-
34.0	Prepaid Legal	-	-	-	-	-	-	-	-
34.0	Bail Bonds	-	-	-	-	-	-	-	-
34.0	Glass	-	-	-	-	-	-	-	-
34.0	Title	-	-	-	-	-	-	-	-
34.0	Livestock	-	-	-	-	-	-	-	-
34.0	Industrial Extended Coverage	-	-	-	-	-	-	-	-
34.0	Mobile Home Multiple Peril	-	-	-	-	-	-	-	-
34.0	Mobile Home Physical Damage	-	-	-	-	-	-	-	-
34.0	Reinsurance	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-
Total		-	-	-	-	-	-	-	-

Nationwide
Year 3

2

Annual Statement Line	Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
1.0	Fire	-	-	-	-	-	-	-	-
2.1	Allied Lines	-	-	-	-	-	-	-	-
2.2	Multiple Peril Crop	-	-	-	-	-	-	-	-
2.3	Federal Flood	-	-	-	-	-	-	-	-
2.4	Private Crop	-	-	-	-	-	-	-	-
2.5	Private Flood	-	-	-	-	-	-	-	-
3.0	Farmowners Multiple Peril	-	-	-	-	-	-	-	-
4.0	Homeowners Multiple Peril	-	-	-	-	-	-	-	-
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-	-	-	-	-	-
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-	-	-	-	-	-
6.0	Mortgage Guaranty	-	-	-	-	-	-	-	-
8.0	Ocean Marine	-	-	-	-	-	-	-	-
9.0	Inland Marine	-	-	-	-	-	-	-	-
10.0	Financial Guaranty	-	-	-	-	-	-	-	-
11.0	Medical Professional Liability	-	-	-	-	-	-	-	-
12.0	Earthquake	-	-	-	-	-	-	-	-
13.0	Group Accident & Health	-	-	-	-	-	-	-	-
14.0	Credit A&H (Group & Individual)	-	-	-	-	-	-	-	-
15.1	Collectively Renewable A&H	-	-	-	-	-	-	-	-
15.2	Non-Cancellable A&H	-	-	-	-	-	-	-	-
15.3	Guaranteed Renewable A&H	-	-	-	-	-	-	-	-
15.4	Non-Renewable for Stated Reasons Only	-	-	-	-	-	-	-	-
15.5	Other Accident Only	-	-	-	-	-	-	-	-
15.6	Medicare Title XVIII Exempt From State Taxes or Fees	-	-	-	-	-	-	-	-
15.7	All Other A&H	-	-	-	-	-	-	-	-
15.8	Federal Employees Health Benefits Plan Premium	-	-	-	-	-	-	-	-
16.0	Workers' Compensation	-	-	-	-	-	-	-	-
17.1	Other Liability—Occurrence	-	-	-	-	-	-	-	-
17.2	Other Liability—Claims Made	-	-	-	-	-	-	-	-
17.3	Excess Workers' Compensation	-	-	-	-	-	-	-	-
18.0	Products Liability	-	-	-	-	-	-	-	-
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-	-	-	-	-	-
19.2	Other Private Passenger Auto Liability	-	-	-	-	-	-	-	-
19.3	Commercial Auto No-Fault (PIP)	-	-	-	-	-	-	-	-
19.4	Other Commercial Auto Liability	-	-	-	-	-	-	-	-
21.1	Private Passenger Auto Physical Damage	-	-	-	-	-	-	-	-
21.2	Commercial Auto Physical Damage	-	-	-	-	-	-	-	-
22.0	Aircraft (All Perils)	-	-	-	-	-	-	-	-
23.0	Fidelity	-	-	-	-	-	-	-	-
24.0	Surety	-	-	-	-	-	-	-	-
26.0	Burglary and Theft	-	-	-	-	-	-	-	-
27.0	Boiler and Machinery	-	-	-	-	-	-	-	-
28.0	Credit	-	-	-	-	-	-	-	-
30.0	Warranty	-	-	-	-	-	-	-	-
34.0	Prepaid Legal	-	-	-	-	-	-	-	-
34.0	Bail Bonds	-	-	-	-	-	-	-	-
34.0	Glass	-	-	-	-	-	-	-	-
34.0	Title	-	-	-	-	-	-	-	-
34.0	Livestock	-	-	-	-	-	-	-	-
34.0	Industrial Extended Coverage	-	-	-	-	-	-	-	-
34.0	Mobile Home Multiple Peril	-	-	-	-	-	-	-	-
34.0	Mobile Home Physical Damage	-	-	-	-	-	-	-	-
34.0	Reinsurance	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-
	Total	-	-	-	-	-	-	-	-

Applicant Company Name:
(Property & Casualty Insurance Company)
Authorized Premium by LOB (Aggregate) - Planned Premium Volume By Line of Business
Amounts in Whole Dollars

Applicant Company Name

Authorized Year 1		0							
Annual Statement Line	Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premuims Earned	Ceded Premiums Earned	Net Premiums Earned
1.0	Fire				-				-
2.1	Allied Lines				-				-
2.2	Multiple Peril Crop				-				-
2.3	Federal Flood				-				-
2.4	Private Crop				-				-
2.5	Private Flood				-				-
3.0	Farmowners Multiple Peril				-				-
4.0	Homeowners Multiple Peril				-				-
5.1	Commercial Multiple Peril (Non-Liability Portion)				-				-
5.2	Commercial Multiple Peril (Liability Portion)				-				-
6.0	Mortgage Guaranty				-				-
8.0	Ocean Marine				-				-
9.0	Inland Marine				-				-
10.0	Financial Guaranty				-				-
11.0	Medical Professional Liability				-				-
12.0	Earthquake				-				-
13.0	Group Accident & Health				-				-
14.0	Credit A&H (Group & Individual)				-				-
15.1	Collectively Renewable A&H				-				-
15.2	Non-Cancellable A&H				-				-
15.3	Guaranteed Renewable A&H				-				-
15.4	Non-Renewable for Stated Reasons Only				-				-
15.5	Other Accident Only				-				-
15.6	Medicare Title XVIII Exempt From State Taxes or Fees				-				-
15.7	All Other A&H				-				-
15.8	Federal Employees Health Benefits Plan Premium				-				-
16.0	Workers' Compensation				-				-
17.1	Other Liability—Occurrence				-				-
17.2	Other Liability—Claims Made				-				-
17.3	Excess Workers' Compensation				-				-
18.0	Products Liability				-				-
19.1	Private Passenger Auto No-Fault (PIP)				-				-
19.2	Other Private Passenger Auto Liability				-				-
19.3	Commercial Auto No-Fault (PIP)				-				-
19.4	Other Commercial Auto Liability				-				-
21.1	Private Passenger Auto Physical Damage				-				-
21.2	Commercial Auto Physical Damage				-				-
22.0	Aircraft (All Perils)				-				-
23.0	Fidelity				-				-
24.0	Surety				-				-
26.0	Burglary and Theft				-				-
27.0	Boiler and Machinery				-				-
28.0	Credit				-				-
30.0	Warranty				-				-
34.0	Prepaid Legal				-				-
34.0	Bail Bonds				-				-
34.0	Glass				-				-
34.0	Title				-				-
34.0	Livestock				-				-
34.0	Industrial Extended Coverage				-				-
34.0	Mobile Home Multiple Peril				-				-
34.0	Mobile Home Physical Damage				-				-
34.0	Reinsurance				-				-
34.0	Other				-				-
34.0	Other				-				-
34.0	Other				-				-
Total		-	-	-	-	-	-	-	-

Authorized									
Year 2	1								
Annual Statement									
Line	Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
1.0	Fire				-				-
2.1	Allied Lines				-				-
2.2	Multiple Peril Crop				-				-
2.3	Federal Flood				-				-
2.4	Private Crop				-				-
2.5	Private Flood				-				-
3.0	Farmowners Multiple Peril				-				-
4.0	Homeowners Multiple Peril				-				-
5.1	Commercial Multiple Peril (Non-Liability Portion)				-				-
5.2	Commercial Multiple Peril (Liability Portion)				-				-
6.0	Mortgage Guaranty				-				-
8.0	Ocean Marine				-				-
9.0	Inland Marine				-				-
10.0	Financial Guaranty				-				-
11.0	Medical Professional Liability				-				-
12.0	Earthquake				-				-
13.0	Group Accident & Health				-				-
14.0	Credit A&H (Group & Individual)				-				-
15.1	Collectively Renewable A&H				-				-
15.2	Non-Cancellable A&H				-				-
15.3	Guaranteed Renewable A&H				-				-
15.4	Non-Renewable for Stated Reasons Only				-				-
15.5	Other Accident Only				-				-
15.6	Medicare Title XVIII Exempt From State Taxes or Fees				-				-
15.7	All Other A&H				-				-
15.8	Federal Employees Health Benefits Plan Premium				-				-
16.0	Workers' Compensation				-				-
17.1	Other Liability—Occurrence				-				-
17.2	Other Liability—Claims Made				-				-
17.3	Excess Workers' Compensation				-				-
18.0	Products Liability				-				-
19.1	Private Passenger Auto No-Fault (PIP)				-				-
19.2	Other Private Passenger Auto Liability				-				-
19.3	Commercial Auto No-Fault (PIP)				-				-
19.4	Other Commercial Auto Liability				-				-
21.1	Private Passenger Auto Physical Damage				-				-
21.2	Commercial Auto Physical Damage				-				-
22.0	Aircraft (All Perils)				-				-
23.0	Fidelity				-				-
24.0	Surety				-				-
26.0	Burglary and Theft				-				-
27.0	Boiler and Machinery				-				-
28.0	Credit				-				-
30.0	Warranty				-				-
34.0	Prepaid Legal				-				-
34.0	Bail Bonds				-				-
34.0	Glass				-				-
34.0	Title				-				-
34.0	Livestock				-				-
34.0	Industrial Extended Coverage				-				-
34.0	Mobile Home Multiple Peril				-				-
34.0	Mobile Home Physical Damage				-				-
34.0	Reinsurance				-				-
34.0	Other				-				-
34.0	Other				-				-
34.0	Other				-				-
Total		-	-	-	-	-	-	-	-

Year 3 2

2

Annual Statement		Direct Premiums	Assumed Premiums	Ceded Premiums		Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
Line	Description	Written	Written	Written	Net Premiums Written	Earned	Earned	Earned	Earned
1.0	Fire				-				-
2.1	Allied Lines				-				-
2.2	Multiple Peril Crop				-				-
2.3	Federal Flood				-				-
2.4	Private Crop				-				-
2.5	Private Flood				-				-
3.0	Farmowners Multiple Peril				-				-
4.0	Homeowners Multiple Peril				-				-
5.1	Commercial Multiple Peril (Non-Liability Portion)				-				-
5.2	Commercial Multiple Peril (Liability Portion)				-				-
6.0	Mortgage Guaranty				-				-
8.0	Ocean Marine				-				-
9.0	Inland Marine				-				-
10.0	Financial Guaranty				-				-
11.0	Medical Professional Liability				-				-
12.0	Earthquake				-				-
13.0	Group Accident & Health				-				-
14.0	Credit A&H (Group & Individual)				-				-
15.1	Collectively Renewable A&H				-				-
15.2	Non-Cancellable A&H				-				-
15.3	Guaranteed Renewable A&H				-				-
15.4	Non-Renewable for Stated Reasons Only				-				-
15.5	Other Accident Only				-				-
15.6	Medicare Title XVIII Exempt From State Taxes or Fees				-				-
15.7	All Other A&H				-				-
15.8	Federal Employees Health Benefits Plan Premium				-				-
16.0	Workers' Compensation				-				-
17.1	Other Liability—Occurrence				-				-
17.2	Other Liability—Claims Made				-				-
17.3	Excess Workers' Compensation				-				-
18.0	Products Liability				-				-
19.1	Private Passenger Auto No-Fault (PIP)				-				-
19.2	Other Private Passenger Auto Liability				-				-
19.3	Commercial Auto No-Fault (PIP)				-				-
19.4	Other Commercial Auto Liability				-				-
21.1	Private Passenger Auto Physical Damage				-				-
21.2	Commercial Auto Physical Damage				-				-
22.0	Aircraft (All Perils)				-				-
23.0	Fidelity				-				-
24.0	Surety				-				-
26.0	Burglary and Theft				-				-
27.0	Boiler and Machinery				-				-
28.0	Credit				-				-
30.0	Warranty				-				-
34.0	Prepaid Legal				-				-
34.0	Bail Bonds				-				-
34.0	Glass				-				-
34.0	Title				-				-
34.0	Livestock				-				-
34.0	Industrial Extended Coverage				-				-
34.0	Mobile Home Multiple Peril				-				-
34.0	Mobile Home Physical Damage				-				-
34.0	Reinsurance				-				-
34.0	Other				-				-
34.0	Other				-				-
34.0	Other				-				-
	Total	-	-	-	-	-	-	-	-

Applicant Company Name:
(Property & Casualty Insurance Company)

Applicant Company Name

Nationwide Incurred Loss Summary By Line of Business

Amounts in Whole Dollars

The Nationwide Incurred Loss Summary by LOB page is automatically calculated. It is calculated based on projected incurred losses by line of business for each state in which the company is already licensed and authorized to write business and projected incurred losses by line of business for those states in which the company is applying to be licensed and authorized. The projected incurred losses will pull from the Authorized Premium By LOB tab and individual state tabs.

Nationwide							
Year 1	0						
Annual		Direct Losses		Ceded Losses Incurred		Net Losses Incurred	
Statement Line	Description	Incurred *	Assumed Losses Incurred *	*	*	*	*
1.0	Fire	-	-	-	-	-	-
2.1	Allied Lines	-	-	-	-	-	-
2.2	Multiple Peril Crop	-	-	-	-	-	-
2.3	Federal Flood	-	-	-	-	-	-
2.4	Private Crop	-	-	-	-	-	-
2.5	Private Flood	-	-	-	-	-	-
3.0	Farmowners Multiple Peril	-	-	-	-	-	-
4.0	Homeowners Multiple Peril	-	-	-	-	-	-
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-	-	-	-
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-	-	-	-
6.0	Mortgage Guaranty	-	-	-	-	-	-
8.0	Ocean Marine	-	-	-	-	-	-
9.0	Inland Marine	-	-	-	-	-	-
10.0	Financial Guaranty	-	-	-	-	-	-
11.0	Medical Professional Liability	-	-	-	-	-	-
12.0	Earthquake	-	-	-	-	-	-
13.0	Group Accident & Health	-	-	-	-	-	-
14.0	Credit A&H (Group & Individual)	-	-	-	-	-	-
15.1	Collectively Renewable A&H	-	-	-	-	-	-
15.2	Non-Cancellable A&H	-	-	-	-	-	-
15.3	Guaranteed Renewable A&H	-	-	-	-	-	-
15.4	Non-Renewable for Stated Reasons Only	-	-	-	-	-	-
15.5	Other Accident Only	-	-	-	-	-	-
15.6	Medicare Title XVIII exempt from state taxes or fees	-	-	-	-	-	-
15.7	All Other A&H	-	-	-	-	-	-
15.8	Federal Employees Health Benefits-Plan Premium	-	-	-	-	-	-
16.0	Workers' Compensation	-	-	-	-	-	-
17.1	Other Liability—Occurrence	-	-	-	-	-	-
17.2	Other Liability—Claims Made	-	-	-	-	-	-
17.3	Excess Workers' Compensation	-	-	-	-	-	-
18.0	Products Liability	-	-	-	-	-	-
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-	-	-	-
19.2	Other Private Passenger Auto Liability	-	-	-	-	-	-
19.3	Commercial Auto No-Fault (PIP)	-	-	-	-	-	-
19.4	Other Commercial Auto Liability	-	-	-	-	-	-
21.1	Private Passenger Auto Physical Damage	-	-	-	-	-	-
21.2	Commercial Auto Physical Damage	-	-	-	-	-	-
22.0	Aircraft (All Perils)	-	-	-	-	-	-
23.0	Fidelity	-	-	-	-	-	-
24.0	Surety	-	-	-	-	-	-
26.0	Burglary and Theft	-	-	-	-	-	-
27.0	Boiler and Machinery	-	-	-	-	-	-
28.0	Credit	-	-	-	-	-	-
30.0	Warranty	-	-	-	-	-	-
34.0	Prepaid Legal	-	-	-	-	-	-
34.0	Bail Bonds	-	-	-	-	-	-
34.0	Glass	-	-	-	-	-	-
34.0	Title	-	-	-	-	-	-
34.0	Livestock	-	-	-	-	-	-
34.0	Industrial Extended Coverage	-	-	-	-	-	-
34.0	Mobile Home Multiple Peril	-	-	-	-	-	-
34.0	Mobile Home Physical Damage	-	-	-	-	-	-
34.0	Reinsurance	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-
Total		-	-	-	-	-	-

Verification from P & L

-

* Include loss adjustment expenses.

Nationwide
Year 2

1

Annual Statement Line	Description	Direct Losses		Ceded Losses Incurred		Net Losses Incurred	
		Incurred *	Assumed Losses Incurred *	*		*	
1.0	Fire	-	-	-		-	
2.0	Allied Lines	-	-	-		-	
2.2	Multiple Peril Crop	-	-	-		-	
2.3	Federal Flood	-	-	-		-	
2.4	Private Crop	-	-	-		-	
2.5	Private Flood	-	-	-		-	
3.0	Farmowners Multiple Peril	-	-	-		-	
4.0	Homeowners Multiple Peril	-	-	-		-	
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-		-	
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-		-	
6.0	Mortgage Guaranty	-	-	-		-	
8.0	Ocean Marine	-	-	-		-	
9.0	Inland Marine	-	-	-		-	
10.0	Financial Guaranty	-	-	-		-	
11.0	Medical Professional Liability	-	-	-		-	
12.0	Earthquake	-	-	-		-	
13.0	Group Accident & Health	-	-	-		-	
14.0	Credit A&H (Group & Individual)	-	-	-		-	
15.1	Collectively Renewable A&H	-	-	-		-	
15.2	Non-Cancellable A&H	-	-	-		-	
15.3	Guaranteed Renewable A&H	-	-	-		-	
15.4	Non-Renewable for Stated Reasons Only	-	-	-		-	
15.5	Other Accident Only	-	-	-		-	
15.6	Medicare Title XVIII exempt from state taxes or fees	-	-	-		-	
15.7	All Other A&H	-	-	-		-	
15.8	Federal Employees Health Benefits-Plan Premium	-	-	-		-	
16.0	Workers' Compensation	-	-	-		-	
17.1	Other Liability—Occurrence	-	-	-		-	
17.2	Other Liability—Claims Made	-	-	-		-	
17.3	Excess Workers' Compensation	-	-	-		-	
18.0	Products Liability	-	-	-		-	
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-		-	
19.2	Other Private Passenger Auto Liability	-	-	-		-	
19.3	Commercial Auto No-Fault (PIP)	-	-	-		-	
19.4	Other Commercial Auto Liability	-	-	-		-	
21.1	Private Passenger Auto Physical Damage	-	-	-		-	
21.2	Commercial Auto Physical Damage	-	-	-		-	
22.0	Aircraft (All Perils)	-	-	-		-	
23.0	Fidelity	-	-	-		-	
24.0	Surety	-	-	-		-	
26.0	Burglary and Theft	-	-	-		-	
27.0	Boiler and Machinery	-	-	-		-	
28.0	Credit	-	-	-		-	
30.0	Warranty	-	-	-		-	
34.0	Prepaid Legal	-	-	-		-	
34.0	Bail Bonds	-	-	-		-	
34.0	Glass	-	-	-		-	
34.0	Title	-	-	-		-	
34.0	Livestock	-	-	-		-	
34.0	Industrial Extended Coverage	-	-	-		-	
34.0	Mobile Home Multiple Peril	-	-	-		-	
34.0	Mobile Home Physical Damage	-	-	-		-	
34.0	Reinsurance	-	-	-		-	
34.0	Other	-	-	-		-	
34.0	Other	-	-	-		-	
34.0	Other	-	-	-		-	
	Total	-	-	-		-	
	Verification from P & L						

* Include loss adjustment expenses.

Nationwide
Year 3

2

Annual Statement Line	Description	Direct Losses Incurred *	Assumed Losses Incurred *	Ceded Losses Incurred *	Net Losses Incurred *
1.0	Fire	-	-	-	-
2.0	Allied Lines	-	-	-	-
2.2	Multiple Peril Crop	-	-	-	-
2.3	Federal Flood	-	-	-	-
2.4	Private Crop	-	-	-	-
2.5	Private Flood	-	-	-	-
3.0	Farmowners Multiple Peril	-	-	-	-
4.0	Homeowners Multiple Peril	-	-	-	-
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-	-
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-	-
6.0	Mortgage Guaranty	-	-	-	-
8.0	Ocean Marine	-	-	-	-
9.0	Inland Marine	-	-	-	-
10.0	Financial Guaranty	-	-	-	-
11.0	Medical Professional Liability	-	-	-	-
12.0	Earthquake	-	-	-	-
13.0	Group Accident & Health	-	-	-	-
14.0	Credit A&H (Group & Individual)	-	-	-	-
15.1	Collectively Renewable A&H	-	-	-	-
15.2	Non-Cancellable A&H	-	-	-	-
15.3	Guaranteed Renewable A&H	-	-	-	-
15.4	Non-Renewable for Stated Reasons Only	-	-	-	-
15.5	Other Accident Only	-	-	-	-
15.6	Medicare Title XVIII exempt from state taxes or fees	-	-	-	-
15.7	All Other A&H	-	-	-	-
15.8	Federal Employees Health Benefits-Plan Premium	-	-	-	-
16.0	Workers' Compensation	-	-	-	-
17.1	Other Liability—Occurrence	-	-	-	-
17.2	Other Liability—Claims Made	-	-	-	-
17.3	Excess Workers' Compensation	-	-	-	-
18.0	Products Liability	-	-	-	-
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-	-
19.2	Other Private Passenger Auto Liability	-	-	-	-
19.3	Commercial Auto No-Fault (PIP)	-	-	-	-
19.4	Other Commercial Auto Liability	-	-	-	-
21.1	Private Passenger Auto Physical Damage	-	-	-	-
21.2	Commercial Auto Physical Damage	-	-	-	-
22.0	Aircraft (All Perils)	-	-	-	-
23.0	Fidelity	-	-	-	-
24.0	Surety	-	-	-	-
26.0	Burglary and Theft	-	-	-	-
27.0	Boiler and Machinery	-	-	-	-
28.0	Credit	-	-	-	-
30.0	Warranty	-	-	-	-
34.0	Prepaid Legal	-	-	-	-
34.0	Bail Bonds	-	-	-	-
34.0	Glass	-	-	-	-
34.0	Title	-	-	-	-
34.0	Livestock	-	-	-	-
34.0	Industrial Extended Coverage	-	-	-	-
34.0	Mobile Home Multiple Peril	-	-	-	-
34.0	Mobile Home Physical Damage	-	-	-	-
34.0	Reinsurance	-	-	-	-
34.0	Other	-	-	-	-
34.0	Other	-	-	-	-
34.0	Other	-	-	-	-
Total		-	-	-	-
Verification from P & L					-

* Include loss adjustment expenses.

Applicant Company Name:
(Property & Casualty Insurance Company)
Authorized Incurred Loss Summary By Line of Business
Amounts in Whole Dollars

Applicant Company Name

Authorized Incurred Loss by LOB (Aggregate)
Year 1 0

Annual Statement		Direct Losses	Assumed Losses	Ceded Losses	Net Losses
Line	Description	Incurred *	Incurred *	Incurred *	Incurred *
1.0	Fire				-
2.0	Allied Lines				-
2.2	Multiple Peril Crop				-
2.3	Federal Flood				-
2.4	Private Crop				-
2.5	Private Flood				-
3.0	Farmowners Multiple Peril				-
4.0	Homeowners Multiple Peril				-
5.1	Commercial Multiple Peril (Non-Liability Portion)				-
5.2	Commercial Multiple Peril (Liability Portion)				-
6.0	Mortgage Guaranty				-
8.0	Ocean Marine				-
9.0	Inland Marine				-
10.0	Financial Guaranty				-
11.0	Medical Professional Liability				-
12.0	Earthquake				-
13.0	Group Accident & Health				-
14.0	Credit A&H (Group & Individual)				-
15.1	Collectively Renewable A&H				-
15.2	Non-Cancellable A&H				-
15.3	Guaranteed Renewable A&H				-
15.4	Non-Renewable for Stated Reasons Only				-
15.5	Other Accident Only				-
15.6	Medicare Title XVIII exempt from state taxes or fees				-
15.7	All Other A&H				-
15.8	Federal Employees Health Benefits-Plan Premium				-
16.0	Workers' Compensation				-
17.1	Other Liability—Occurrence				-
17.2	Other Liability—Claims Made				-
17.3	Excess Workers' Compensation				-
18.0	Products Liability				-
19.1	Private Passenger Auto No-Fault (PIP)				-
19.2	Other Private Passenger Auto Liability				-
19.3	Commercial Auto No-Fault (PIP)				-
19.4	Other Commercial Auto Liability				-
21.1	Private Passenger Auto Physical Damage				-
21.2	Commercial Auto Physical Damage				-
22.0	Aircraft (All Perils)				-
23.0	Fidelity				-
24.0	Surety				-
26.0	Burglary and Theft				-
27.0	Boiler and Machinery				-
28.0	Credit				-
30.0	Warranty				-
34.0	Prepaid Legal				-
34.0	Bail Bonds				-
34.0	Glass				-
34.0	Title				-
34.0	Livestock				-
34.0	Industrial Extended Coverage				-
34.0	Mobile Home Multiple Peril				-
34.0	Mobile Home Physical Damage				-
34.0	Reinsurance				-
34.0	Other				-
34.0	Other				-
34.0	Other				-
Total		-	-	-	-

* Include loss adjustment expenses.

Authorized Incurred Loss by LOB (Aggregate)

Year 2		1				
Annual Statement			Direct Losses	Assumed Losses	Ceded Losses	Net Losses
Line	Description		Incurred *	Incurred *	Incurred *	Incurred *
1.0	Fire					-
2.0	Allied Lines					-
2.2	Multiple Peril Crop					-
2.3	Federal Flood					-
2.4	Private Crop					-
2.5	Private Flood					-
3.0	Farmowners Multiple Peril					-
4.0	Homeowners Multiple Peril					-
5.1	Commercial Multiple Peril (Non-Liability Portion)					-
5.2	Commercial Multiple Peril (Liability Portion)					-
6.0	Mortgage Guaranty					-
8.0	Ocean Marine					-
9.0	Inland Marine					-
10.0	Financial Guaranty					-
11.0	Medical Professional Liability					-
12.0	Earthquake					-
13.0	Group Accident & Health					-
14.0	Credit A&H (Group & Individual)					-
15.1	Collectively Renewable A&H					-
15.2	Non-Cancellable A&H					-
15.3	Guaranteed Renewable A&H					-
15.4	Non-Renewable for Stated Reasons Only					-
15.5	Other Accident Only					-
15.6	Medicare Title XVIII exempt form state taxes or fees					-
15.7	All Other A&H					-
15.8	Federal Employees Health Benefits-Plan Premium					-
16.0	Workers' Compensation					-
17.1	Other Liability—Occurrence					-
17.2	Other Liability—Claims Made					-
17.3	Excess Workers' Compensation					-
18.0	Products Liability					-
19.1	Private Passenger Auto No-Fault (PIP)					-
19.2	Other Private Passenger Auto Liability					-
19.3	Commercial Auto No-Fault (PIP)					-
19.4	Other Commercial Auto Liability					-
21.1	Private Passenger Auto Physical Damage					-
21.2	Commercial Auto Physical Damage					-
22.0	Aircraft (All Perils)					-
23.0	Fidelity					-
24.0	Surety					-
26.0	Burglary and Theft					-
27.0	Boiler and Machinery					-
28.0	Credit					-
30.0	Warranty					-
34.0	Prepaid Legal					-
34.0	Bail Bonds					-
34.0	Glass					-
34.0	Title					-
34.0	Livestock					-
34.0	Industrial Extended Coverage					-
34.0	Mobile Home Multiple Peril					-
34.0	Mobile Home Physical Damage					-
34.0	Reinsurance					-
34.0	Other					-
34.0	Other					-
34.0	Other					-
Total			-	-	-	-

Authorized Incurred Loss by LOB (Aggregate)

Year 3		2				
Annual Statement			Direct Losses	Assumed Losses	Ceded Losses	Net Losses
Line	Description		Incurred *	Incurred *	Incurred *	Incurred *
1.0	Fire					-
2.0	Allied Lines					-
2.2	Multiple Peril Crop					-
2.3	Federal Flood					-
2.4	Private Crop					-
2.5	Private Flood					-
3.0	Farmowners Multiple Peril					-
4.0	Homeowners Multiple Peril					-
5.1	Commercial Multiple Peril (Non-Liability Portion)					-
5.2	Commercial Multiple Peril (Liability Portion)					-
6.0	Mortgage Guaranty					-
8.0	Ocean Marine					-
9.0	Inland Marine					-
10.0	Financial Guaranty					-
11.0	Medical Professional Liability					-
12.0	Earthquake					-
13.0	Group Accident & Health					-
14.0	Credit A&H (Group & Individual)					-
15.1	Collectively Renewable A&H					-
15.2	Non-Cancellable A&H					-
15.3	Guaranteed Renewable A&H					-
15.4	Non-Renewable for Stated Reasons Only					-
15.5	Other Accident Only					-
15.6	Medicare Title XVIII exempt from state taxes or fees					-
15.7	All Other A&H					-
15.8	Federal Employees Health Benefits-Plan Premium					-
16.0	Workers' Compensation					-
17.1	Other Liability—Occurrence					-
17.2	Other Liability—Claims Made					-
17.3	Excess Workers' Compensation					-
18.0	Products Liability					-
19.1	Private Passenger Auto No-Fault (PIP)					-
19.2	Other Private Passenger Auto Liability					-
19.3	Commercial Auto No-Fault (PIP)					-
19.4	Other Commercial Auto Liability					-
21.1	Private Passenger Auto Physical Damage					-
21.2	Commercial Auto Physical Damage					-
22.0	Aircraft (All Perils)					-
23.0	Fidelity					-
24.0	Surety					-
26.0	Burglary and Theft					-
27.0	Boiler and Machinery					-
28.0	Credit					-
30.0	Warranty					-
34.0	Prepaid Legal					-
34.0	Bail Bonds					-
34.0	Glass					-
34.0	Title					-
34.0	Livestock					-
34.0	Industrial Extended Coverage					-
34.0	Mobile Home Multiple Peril					-
34.0	Mobile Home Physical Damage					-
34.0	Reinsurance					-
34.0	Other					-
34.0	Other					-
34.0	Other					-
Total			-	-	-	-

* Include loss adjustment expenses.

Applicant Company Name:
(Property & Casualty Insurance Company)
Net Premium and Loss Developments By Line of Business
Amounts in Whole Dollars

Applicant Company Name

Nationwide

Annual Statement Line	Description	Premiums Earned	0 Losses Incurred*	Loss Ratio	Premiums Earned	1 Losses Incurred*	Loss Ratio	Premiums Earned	2 Losses Incurred*	Loss Ratio
1.0	Fire	-	-	-	-	-	-	-	-	-
2.1	Allied Lines	-	-	-	-	-	-	-	-	-
2.2	Multiple Peril Crop	-	-	-	-	-	-	-	-	-
2.3	Federal Flood	-	-	-	-	-	-	-	-	-
2.4	Private Crop	-	-	-	-	-	-	-	-	-
2.5	Private Flood	-	-	-	-	-	-	-	-	-
3.0	Farmowners Multiple Peril	-	-	-	-	-	-	-	-	-
4.0	Homeowners Multiple Peril	-	-	-	-	-	-	-	-	-
5.1	Commercial Multiple Peril (Non-Liability Portion)	-	-	-	-	-	-	-	-	-
5.2	Commercial Multiple Peril (Liability Portion)	-	-	-	-	-	-	-	-	-
6.0	Mortgage Guaranty	-	-	-	-	-	-	-	-	-
8.0	Ocean Marine	-	-	-	-	-	-	-	-	-
9.0	Inland Marine	-	-	-	-	-	-	-	-	-
10.0	Financial Guaranty	-	-	-	-	-	-	-	-	-
11.0	Medical Professional Liability	-	-	-	-	-	-	-	-	-
12.0	Earthquake	-	-	-	-	-	-	-	-	-
13.0	Group Accident & Health	-	-	-	-	-	-	-	-	-
14.0	Credit A&H (Group & Individual)	-	-	-	-	-	-	-	-	-
15.1	Collectively Renewable A&H	-	-	-	-	-	-	-	-	-
15.2	Non-Cancellable A&H	-	-	-	-	-	-	-	-	-
15.3	Guaranteed Renewable A&H	-	-	-	-	-	-	-	-	-
15.4	Non-Renewable for Stated Reasons Only	-	-	-	-	-	-	-	-	-
15.5	Other Accident Only	-	-	-	-	-	-	-	-	-
15.6	Medicare Title XVIII exempt from state taxes or fees	-	-	-	-	-	-	-	-	-
15.7	All Other A&H	-	-	-	-	-	-	-	-	-
15.8	Federal Employees Health Benefits Plan Premium	-	-	-	-	-	-	-	-	-
16.0	Workers' Compensation	-	-	-	-	-	-	-	-	-
17.1	Other Liability—Occurrence	-	-	-	-	-	-	-	-	-
17.2	Other Liability - Claims Made	-	-	-	-	-	-	-	-	-
17.3	Excess Workers' Compensation	-	-	-	-	-	-	-	-	-
18.0	Products Liability	-	-	-	-	-	-	-	-	-
19.1	Private Passenger Auto No-Fault (PIP)	-	-	-	-	-	-	-	-	-
19.2	Other Private Passenger Auto Liability	-	-	-	-	-	-	-	-	-
19.3	Commercial Auto No-Fault (PIP)	-	-	-	-	-	-	-	-	-
19.4	Other Commercial Auto Liability	-	-	-	-	-	-	-	-	-
21.1	Private Passenger Auto Physical Damage	-	-	-	-	-	-	-	-	-
21.2	Commercial Auto Physical Damage	-	-	-	-	-	-	-	-	-
22.0	Aircraft (All Perils)	-	-	-	-	-	-	-	-	-
23.0	Fidelity	-	-	-	-	-	-	-	-	-
24.0	Surety	-	-	-	-	-	-	-	-	-
26.0	Burglary and Theft	-	-	-	-	-	-	-	-	-
27.0	Boiler and Machinery	-	-	-	-	-	-	-	-	-
28.0	Credit	-	-	-	-	-	-	-	-	-
30.0	Warranty	-	-	-	-	-	-	-	-	-
34.0	Prepaid Legal	-	-	-	-	-	-	-	-	-
34.0	Bail Bonds	-	-	-	-	-	-	-	-	-
34.0	Glass	-	-	-	-	-	-	-	-	-
34.0	Title	-	-	-	-	-	-	-	-	-
34.0	Livestock	-	-	-	-	-	-	-	-	-
34.0	Industrial Extended Coverage	-	-	-	-	-	-	-	-	-
34.0	Mobile Home Multiple Peril	-	-	-	-	-	-	-	-	-
34.0	Mobile Home Physical Damage	-	-	-	-	-	-	-	-	-
34.0	Reinsurance	-	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-	-
34.0	Other	-	-	-	-	-	-	-	-	-
Total		0	0	0%	0	0	0%	0	0	0%
Verification from P & L - should equal line above.										

* Include loss adjustment expenses.

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.

Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

UCAA Proforma Financial Statements
Life & Health Insurer

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.
7. For additional guidance, refer to the FAQ's on the UCAA webpage.

Enter the Applicant Company Name:

Applicant Company Name

Year 1:

Year 2:

1

Year 3:

2

☐ AK	Alaska	☐ MT	Montana
☐ AL	Alabama	☐ NC	North Carolina
☐ AR	Arkansas	☐ ND	North Dakota
☐ AS	American Samoa	☐ NE	Nebraska
☐ AZ	Arizona	☐ NH	New Hampshire
☐ CA	California	☐ NJ	New Jersey
☐ CO	Colorado	☐ NM	New Mexico
☐ CT	Connecticut	☐ NV	Nevada
☐ DC	District Of Columbia	☐ NY	New York
☐ DE	Delaware	☐ OH	Ohio
☐ FL	Florida	☐ OK	Oklahoma
☐ GA	Georgia	☐ OR	Oregon
☐ GU	Guam	☐ PA	Pennsylvania
☐ HI	Hawaii	☐ PR	Puerto Rico
☐ IA	Iowa	☐ RI	Rhode Island
☐ ID	Idaho	☐ SC	South Carolina
☐ IL	Illinois	☐ SD	South Dakota
☐ IN	Indiana	☐ TN	Tennessee
☐ KS	Kansas	☐ TX	Texas
☐ KY	Kentucky	☐ UT	Utah
☐ LA	Louisiana	☐ VA	Virginia
☐ MA	Massachusetts	☐ VI	U.S. Virgin Islands
☐ MD	Maryland	☐ VT	Vermont
☐ ME	Maine	☐ WA	Washington
☐ MI	Michigan	☐ WI	Wisconsin
☐ MN	Minnesota	☐ WV	West Virginia
☐ MO	Missouri	☐ WY	Wyoming
☐ MS	Mississippi		



If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Applicant Company Name

Risk-Based Capital Analysis

Applicant Company Name:
(Life, Accident, and Health Insurance Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Dollars)

Applicant Company Name

	0	1	2
1. Net Premiums (All Business)			
2. Net Investment Income			
3. Reinsurance Ceding Commissions			
4. Miscellaneous Income			
5. Total (1+2+3+4)	-	-	-
6. Death Benefits			
7. Matured Endowments			
8. Annuity Benefits			
9. Accident and Health Policy Benefits			
10. Surrender Benefits and Other Fund Withdrawals			
11. Group Conversions			
12. Interest on Policy and Contract Funds			
13. Commissions on Premiums, and Annuity Considerations (Direct Business Only)			
14. Commissions and Expense Allowances on Reinsurance Assumed			
15. Increase in Aggregate Reseves			
16. Net Transer (to) or from Separate Accounts Net of Reinsurance			
17. Other Expenses *			
18. Total Expenses (sum6...17)	-	-	-
19. Net Gain (Loss) from Operations Before Dividends and Federal Income Taxes (5-18)	-	-	-
20. Federal Income Taxes			
21. Net Realized Capital Gains (Losses)			
22. Less Capital Gains Tax			
23. Net Income((19-20)+(21-22))	-	-	-
24. Prior YE Surplus			
25. Net Income	-	-	-
26. Capital Increases			
27. Other Increases (Decreases)			
28. Dividends to Stockholders			
29. YE Surplus	-	-	-

*Itemize in Assumptions

Applicant Company Name:
(Life, Accident, and Health Insurance Company)
Pro Forma Statutory Cash Flow Statement
(In Whole Dollars)

Applicant Company Name

	0	1	2
Cash From Operations			
1. Premiums Collected Net of Reinsurance			
2. Net Investment Income			
3. Miscellaneous Income			
4. Benefit and Loss Related Payments			
5. Net Transfers to Separate Accounts, Segrated Accounts and Protected Cell Accounts			
6. Commissions, Expenses Paid and Aggregate Write-Ins for Deductions			
7. Dividends Paid to Policyholders			
8. Federal and Foreign Income Taxes Paid (Recovered)			
9. Net Cash From Operations (1+2+3-4-5-6-7-8)	-	-	-
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Miscellaneous Sources			
11. Surplus Notes, Capital Notes			
12. Capital and Paid in Surplus, Less Treasury Stock			
13. Borrowed Funds			
14. Net Deposits on Deposit-Type Contracts and Other Insurance Liabilities			
15. Dividends to Stockholders			
16. Other Cash Provided (Applied)			
17. Net Cash from Financing and Miscellaneous Sources (11+12+13+14-15+16)	-	-	-
18. Net Change in Cash, Cash Equivalents and Short -Term Investments (9+10+17)	-	-	-

Applicant Company Name:
(Life, Accident, and Health Insurance Company)
Analysis of Operations by Line of Business
(In Whole Dollars)

Nationwide
Year 1

Applicant Company Name

0	Total	Ordinary			Credit Life (Group & Individual)	Group		Accident and Health			Aggregate of All Other Lines Business
		Life Insurance	Individual Annuities	Supplementary Contracts		Life Insurance (a)	Annuities	Group	Credit (Group and Individual)	Other	
1. Net Premiums (All Business)	-										
2. Net Investment Income	-										
3. Reinsurance Ceding Commissions	-										
4. Miscellaneous Income	-										
5. Total Revenue (1+2+3+4)	-	-	-	-	-	-	-	-	-	-	-
6. Death Benefits	-										
7. Matured Endowments	-										
8. Annuity Benefits	-										
9. Accident and Health Policy Benefits	-										
10. Surrender Benefits and Other Fund Withdrawals	-										
11. Group Conversions	-										
12. Interest Policy and Contract Funds	-										
13. Commissions on Premiums, Annuity Considerations Direct Business Only)	-										
14. Commissions and Expense Allowances on Reinsurance Assumed	-										
15. Increase in Aggregate Reserves	-										
16. Net Transfers to or (from) Separate Accounts Net of Reinsurance	-										
17. Other Expenses	-										
18. Total Expenses (sum6...17)	-	-	-	-	-	-	-	-	-	-	-
19. Net Gain (Loss) from Operations Before Dividends to and Federal Income Taxes (5-18)	-	-	-	-	-	-	-	-	-	-	-
20. Federal Income Taxes	-										
21. Net Realized Capital Gains (Losses)	-										
22. Less Capital Gains Tax	-										
23. Net Income((19-20)+(21-212)	-	-	-	-	-	-	-	-	-	-	-
24. Dividends to Stockholders	-										

Applicant Company Name:
(Life, Accident, and Health Insurance Company)
Analysis of Operations by Line of Business
(In Whole Dollars)

Applicant Company Name

Nationwide
Year 2

1	Total	Ordinary			Credit Life (Group & Individual)	Group		Accident and Health			Aggregate of All Other Lines Business
		Life Insurance	Individual Annuities	Supplementary Contracts		Life Insurance (a)	Annuities	Group	Credit (Group and Individual)	Other	
1. Net Premiums (All Business)	-										
2. Net Investment Income	-										
3. Reinsurance Ceding Commissions	-										
4. Miscellaneous Income	-										
5. Total Revenue (1+2+3+4)	-	-	-	-	-	-	-	-	-	-	-
6. Death Benefits	-										
7. Matured Endowments	-										
8. Annuity Benefits	-										
9. Accident and Health Policy Benefits	-										
10. Surrender Benefits and Other Fund Withdrawals	-										
11. Group Conversions	-										
12. Interest Policy and Contract Funds	-										
13. Commissions on Premiums, Annuity Considerations Direct Business Only)	-										
14. Commissions and Expense Allowances on Reinsurance Assumed	-										
15. Increase in Aggregate Reserves	-										
16. Net Transfers to or (from) Separate Accounts Net of Reinsurance	-										
17. Other Expenses	-										
18. Total Expenses (sum6...17)	-	-	-	-	-	-	-	-	-	-	-
19. Net Gain (Loss) from Operations Before Dividends to and Federal Income Taxes (5-18)	-	-	-	-	-	-	-	-	-	-	-
20. Federal Income Taxes	-										
21. Net Realized Capital Gains (Losses)	-										
22. Less Capital Gains Tax	-										
23. Net Income((19-20)+(21-212)	-	-	-	-	-	-	-	-	-	-	-
24. Dividends to Stockholders	-										

Applicant Company Name:
(Life, Accident, and Health Insurance Company)
Analysis of Operations by Line of Business
(In Whole Dollars)

Nationwide
Year 3

Applicant Company Name

2

Total	Ordinary			Credit Life (Group & Individual)	Group		Accident and Health			Aggregate of All Other Lines Business
	Life Insurance	Individual Annuities	Supplementary Contracts		Life Insurance (a)	Annuities	Group	Credit (Group and Individual)	Other	
1. Net Premiums (All Business)	-									
2. Net Investment Income	-									
3. Reinsurance Ceding Commissions	-									
4. Miscellaneous Income	-									
5. Total Revenue (1+2+3+4)	-	-	-	-	-	-	-	-	-	-
6. Death Benefits	-									
7. Matured Endowments	-									
8. Annuity Benefits	-									
9. Accident and Health Policy Benefits	-									
10. Surrender Benefits and Other Fund Withdrawals	-									
11. Group Conversions	-									
12. Interest Policy and Contract Funds	-									
13. Commissions on Premiums, Annuity Considerations Direct Business Only)	-									
14. Commissions and Expense Allowances on Reinsurance Assumed	-									
15. Increase in Aggregate Reserves	-									
16. Net Transfers to or (from) Separate Accounts Net of Reinsurance	-									
17. Other Expenses	-									
18. Total Expenses (sum6...17)	-	-	-	-	-	-	-	-	-	-
19. Net Gain (Loss) from Operations Before Dividends to and Federal Income Taxes (5-18)	-	-	-	-	-	-	-	-	-	-
20. Federal Income Taxes	-									
21. Net Realized Capital Gains (Losses)	-									
22. Less Capital Gains Tax	-									
23. Net Income((19-20)+(21-212)	-	-	-	-	-	-	-	-	-	-
24. Dividends to Stockholders	-									

Applicant Company Name:
Applicant Company Name
(Life, Accident, and Health Insurance Company)
Nationwide Premium by LOB - Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

The Nationwide Premium by LOB page is automatically calculated. It is calculated based on projected premiums by line of business for each state in which the company is already licensed and authorized to write business and projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums will pull from the Authorized Premium By LOB tab and individual state tabs.

Nationwide					
Year 1		0			
Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums	
1. Ordinary Life Insurance	-	-	-	-	-
2. Ordinary Individual Annuities	-	-	-	-	-
3. Credit Life (Group and Individual)	-	-	-	-	-
4. Group Life Insurance	-	-	-	-	-
5. Group Annuities	-	-	-	-	-
6. Accident and Health Group	-	-	-	-	-
7. Accident and Health Credit (Group and Individual)	-	-	-	-	-
8. Accident and Health Other	-	-	-	-	-
9. Aggregate of All Other Lines of Business	-	-	-	-	-
10. Total	-	-	-	-	-
Nationwide					
Year 2		1			
Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums	
1. Ordinary Life Insurance	-	-	-	-	-
2. Ordinary Individual Annuities	-	-	-	-	-
3. Credit Life (Group and Individual)	-	-	-	-	-
4. Group Life Insurance	-	-	-	-	-
5. Group Annuities	-	-	-	-	-
6. Accident and Health Group	-	-	-	-	-
7. Accident and Health Credit (Group and Individual)	-	-	-	-	-
8. Accident and Health Other	-	-	-	-	-
9. Aggregate of All Other Lines of Business	-	-	-	-	-
10. Total	-	-	-	-	-
Nationwide					
Year 3		2			
Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums	
1. Ordinary Life Insurance	-	-	-	-	-
2. Ordinary Individual Annuities	-	-	-	-	-
3. Credit Life (Group and Individual)	-	-	-	-	-
4. Group Life Insurance	-	-	-	-	-
5. Group Annuities	-	-	-	-	-
6. Accident and Health Group	-	-	-	-	-
7. Accident and Health Credit (Group and Individual)	-	-	-	-	-
8. Accident and Health Other	-	-	-	-	-
9. Aggregate of All Other Lines of Business	-	-	-	-	-
10. Total	-	-	-	-	-

Applicant Company Name:
(Life, Accident, and Health Insurance Company)
Authorized Premium by LOB (Aggregate) - Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Applicant Company Name

Nationwide					
Year 1		0			
Description		Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1.	Ordinary Life Insurance				-
2.	Ordinary Individual Annuities				-
3.	Credit Life (Group and Individual)				-
4.	Group Life Insurance				-
5.	Group Annuities				-
6.	Accident and Health Group				-
7.	Accident and Health Credit (Group and Individual)				-
8.	Accident and Health Other				-
9.	Aggregate of All Other Lines of Business				-
10.	Total	-	-	-	-

Nationwide					
Year 2		1			
Description		Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1.	Ordinary Life Insurance				-
2.	Ordinary Individual Annuities				-
3.	Credit Life (Group and Individual)				-
4.	Group Life Insurance				-
5.	Group Annuities				-
6.	Accident and Health Group				-
7.	Accident and Health Credit (Group and Individual)				-
8.	Accident and Health Other				-
9.	Aggregate of All Other Lines of Business				-
10.	Total	-	-	-	-

Nationwide					
Year 3		2			
Description		Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1.	Ordinary Life Insurance				-
2.	Ordinary Individual Annuities				-
3.	Credit Life (Group and Individual)				-
4.	Group Life Insurance				-
5.	Group Annuities				-
6.	Accident and Health Group				-
7.	Accident and Health Credit (Group and Individual)				-
8.	Accident and Health Other				-
9.	Aggregate of All Other Lines of Business				-
10.	Total	-	-	-	-

UCAA Proforma Financial Statements

List all of the relevant assumptions used to create the proformas.

Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

UCAA Proforma Financial Statements
Title Insurance Company



Instructions

1. Enter the Applicant Company Name below
2. Enter the first year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.
7. For additional guidance, refer to the FAQ's on the UCAA webpage.

Enter the Applicant Company Name:

Applicant Company Name

Year 1:

Year 2:

Year 3:

1

2

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

☐	AK	Alaska	☐	MT	Montana
☐	AL	Alabama	☐	NC	North Carolina
☐	AR	Arkansas	☐	ND	North Dakota
☐	AS	American Samoa	☐	NE	Nebraska
☐	AZ	Arizona	☐	NH	New Hampshire
☐	CA	California	☐	NJ	New Jersey
☐	CO	Colorado	☐	NM	New Mexico
☐	CT	Connecticut	☐	NV	Nevada
☐	DC	District Of Columbia	☐	NY	New York
☐	DE	Delaware	☐	OH	Ohio
☐	FL	Florida	☐	OK	Oklahoma
☐	GA	Georgia	☐	OR	Oregon
☐	GU	Guam	☐	PA	Pennsylvania
☐	HI	Hawaii	☐	PR	Puerto Rico
☐	IA	Iowa	☐	RI	Rhode Island
☐	ID	Idaho	☐	SC	South Carolina
☐	IL	Illinois	☐	SD	South Dakota
☐	IN	Indiana	☐	TN	Tennessee
☐	KS	Kansas	☐	TX	Texas
☐	KY	Kentucky	☐	UT	Utah
☐	LA	Louisiana	☐	VA	Virginia
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands
☐	MD	Maryland	☐	VT	Vermont
☐	ME	Maine	☐	WA	Washington
☐	MI	Michigan	☐	WI	Wisconsin
☐	MN	Minnesota	☐	WV	West Virginia
☐	MO	Missouri	☐	WY	Wyoming
☐	MS	Mississippi			

Updated: January 1, 2019

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Applicant Company Name:
(Title Insurance Company)
Pro Forma Statutory Balance Sheet
(In Whole Numbers)

Applicant Company Name

	0	1	2
<u>Admitted Assets</u>			
1. Bonds			
2. Stocks (Preferred and Common)			
3. Title Plants			
4. Real Estate/Mortgage Loans on Real Estate			
5. Cash/Cash Equivalents/Short-Term Investments			
6. Other Invested Assets			
7. Aggregate Write-Ins for Invested Assets			
8. All Other Admitted Assets			
9. Total Admitted Assets	-	-	-
<u>Liabilities</u>			
10. Known Claims Reserve			
11. Statutory Premium Reserve			
12. Aggregate of Other Reserves Required By Law			
13. Ceded Reinsurance Payable			
14. Payable to Parent, Subsidiaries & Affiliates			
15. All Other Liabilities			
16. Total Liabilities (10+11+12+13+14+15)	-	-	-
<u>Capital and Surplus</u>			
17. Capital Stock			
18. Gross Paid In and Contributed Surplus			
19. Surplus Notes			
20. Unassigned Funds (Surplus)			
21. Aggregate Write-Ins for Other-Than-Special Surplus			
22. Aggregate Write-Ins for Special Surplus			
23. Less Treasury Stock (Common and Preferred)			
24. Suplus as Regards Policyholders (17+18+19+20+21+22-23)	-	-	-
25. Liabilities and Surplus (16+24)	-	-	-

(Title Insurance Company)
Pro Forma Statutory Profit & Loss Statement
(In Whole Numbers)

	0	1	2
1. Title Premiums Earned			
2. Escrow Charges			
3. Other Related Income			
4. Net Losses Incurred			
5. Net Loss Adjustment Expenses Incurred			
6. Direct Commissions & Brokerage			
7. Reinsurance Ceding Commissions			
8. Net Commissions Incurred (6-7)	-	-	-
9. Other Contractual Agreements*			
10. Other Operating Expenses Incurred**			
11. Underwriting Gain (Loss) (1+2+3-(4+5+8+9+10))	-	-	-
12. Net Investment Income			
13. Other Income			
14. Income Taxes Incurred			
15. Net Operating Income (Loss) (11+12+13-14)	-	-	-
16. Prior YE Surplus			
17. Net Income	-	-	-
18. Capital Increases			
19. Other Increases (decreases)			
20. Dividends to Stockholders			
21. YE Surplus	-	-	-
Operating Percentages:			
Net Premiums Earned	100.00%	100.00%	100.00%
22. Net Losses Incurred to Title Insurance Net Premiums Earned (4/(1+2+3))	0.00%	0.00%	0.00%
23. Net Loss Adjustment Expenses Incurred to Title Insurance Net Premium Earned (5/(1+2+3))	0.00%	0.00%	0.00%
24. Other Underwriting Expense to Title Insurance Net Premium Earned ((8+9+10)/(1))	0.00%	0.00%	0.00%
25. Net Underwriting Gain Or (Loss) (11/(1+2+3))	0.00%	0.00%	0.00%
Other Percentages:			
26. Other Underwriting Expenses to Net Premiums Written (8+9+10)/Total Net Premiums Written))	0.00%	0.00%	0.00%
27. Net Loss and Loss Adjustment Expenses Incurred to Title Insurance and Related Income ((4+5)/(1+2+3))	0.00%	0.00%	0.00%

*ie... MGA(excluding amounts included above as agents commissions), service contracts, claims payment contracts

** Itemize in Assumptions

Applicant Company Name:
(Title Insurance Company)
Pro Forma Statutory Cash Flow Statement
(In Whole Numbers)

Applicant Company Name

	0	1	2
1. Premiums Collected Net of Reinsurance			
2. Net Investment Income			
3. Miscellaneous Income			
4. Benefit and Loss Related Payments			
5. Net Transfers to Separate Accounts, Segrated Accounts and Protected Cell Accounts			
6. Commissions, Expenses Paid and Aggregate Write-Ins for Deductions			
7. Dividends Paid to Policyholders			
8. Federal and Foreign Income Taxes Paid (Recovered)			
9. Net Cash From Operations (1+2+3-4-5-6-7-8)	-	-	-
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Miscellaneous Sources			
11. Surplus Notes, Capital Notes			
12. Capital and Paid in Surplus, Less Treasury Stock			
13. Borrowed Funds			
14. Net Deposits on Deposit-Type Contracts and Other Insurance Liabilities			
15. Dividends to Stockholders			
16. Other Cash Provided (Applied)			
17. Net Cash from Financing and Miscellaneous Sources (11+12+13+14-15+16)	-	-	-
18. Net Change in Cash, Cash Equivalents and Short -Term Investments (9+10+17)	-	-	-

Applicant Company Name:
(Title Insurance Company)
Premiums Written to Surplus Ratios
(Amounts in Whole Dollars)

Applicant Company Name

Nationwide								
Year	Direct Premiums Written	Assumed Premiums Written	Gross Premiums Written	Ceded Premiums Written	Net Premiums Written	Gross Written Premiums to Surplus	Net Written Premiums to Surplus	
0	-	-	-	-	-	0.00%	0.00%	
1	-	-	-	-	-	0.00%	0.00%	
2	-	-	-	-	-	0.00%	0.00%	

No data entry is required on this page.

Applicant Company Name: Applicant Company Name
(Title Insurance Company)
Nationwide Planned Premium Volume By Line of Business
(Amounts in Whole Dollars)

The Nationwide Premium by LOB page is automatically calculated. It is calculated based on projected premiums by line of business for each state in which the company is already licensed and authorized to write business and projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums will pull from the Authorized Premium By LOB tab and individual state tabs.

Nationwide

Year 1 0

Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
Title	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-

Nationwide

Year 2 1

Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
Title	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-

Nationwide

Year 3 2

Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
Title	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-

Applicant Company Name: Applicant Company Name
(Title Insurance Company)
Authorized Premium by LOB (Aggregate) - Planned Premium Volume By Line of Business
(Amounts in Whole Dollars)

Authorized
Year 1 0

Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
Title				-				-
Total	-	-	-	-	-	-	-	-

Authorized
Year 2 1

Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
Title				-				-
Total	-	-	-	-	-	-	-	-

Authorized
Year 3 2

Description	Direct Premiums Written	Assumed Premiums Written	Ceded Premiums Written	Net Premiums Written	Direct Premiums Earned	Assumed Premiums Earned	Ceded Premiums Earned	Net Premiums Earned
Title				-				-
Total	-	-	-	-	-	-	-	-

Applicant Company Name: Applicant Company Name
 (Title Insurance Company)
 Incurred Loss Summary By Line of Business
 (Amounts in Whole Dollars)

Nationwide
 Year 1 0

		Assumed Losses	Ceded Losses	
	Description	Direct Losses Incurred	Incurred	Incurred Net Losses Incurred
	Title			-
	Total	-	-	-
	Verification from P & L			-

Nationwide
 Year 2 1

		Assumed Losses	Ceded Losses	
	Description	Direct Losses Incurred	Incurred	Incurred Net Losses Incurred
	Title			-
	Total	-	-	-
	Verification from P & L			-

Nationwide
 Year 3 2

		Assumed Losses	Ceded Losses	
	Description	Direct Losses Incurred	Incurred	Incurred Net Losses Incurred
	Title			-
	Total	-	-	-
	Verification from P & L			-

Applicant Company Name:
(Title Insurance Company)
Nationwide Net Premium and Loss Developments By Line of Business
(Amounts in Whole Dollars)

Applicant Company Name

Description	Premiums Earned	0 Losses Incurred	Loss Ratio	Premiums Earned	1 Losses Incurred	Loss Ratio	Premiums Earned	2 Losses Incurred	Loss Ratio
Title	-	-	0.0%	-	-	0.0%	-	-	0.0%
Total	-	-	0.0%	-	-	0.0%	-	-	0.0%
Verification from P & L - should equal line above.									

UCAA Proforma Financial Statements

List all of the relevant assumptions used to create the proformas.

Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

UCAA Proforma Financial Statements

Health

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with first full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.
7. For additional guidance, refer to the FAQ's on the UCAA webpage.

Enter the Applicant Company Name:

Applicant Company Name

Year 1:

Year 2:

1

Year 3:

2

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets"



☐ AK	Alaska	☐ MT	Montana
☐ AL	Alabama	☐ NC	North Carolina
☐ AR	Arkansas	☐ ND	North Dakota
☐ AS	American Samoa	☐ NE	Nebraska
☐ AZ	Arizona	☐ NH	New Hampshire
☐ CA	California	☐ NJ	New Jersey
☐ CO	Colorado	☐ NM	New Mexico
☐ CT	Connecticut	☐ NV	Nevada
☐ DC	District Of Columbia	☐ NY	New York
☐ DE	Delaware	☐ OH	Ohio
☐ FL	Florida	☐ OK	Oklahoma
☐ GA	Georgia	☐ OR	Oregon
☐ GU	Guam	☐ PA	Pennsylvania
☐ HI	Hawaii	☐ PR	Puerto Rico
☐ IA	Iowa	☐ RI	Rhode Island
☐ ID	Idaho	☐ SC	South Carolina
☐ IL	Illinois	☐ SD	South Dakota
☐ IN	Indiana	☐ TN	Tennessee
☐ KS	Kansas	☐ TX	Texas
☐ KY	Kentucky	☐ UT	Utah
☐ LA	Louisiana	☐ VA	Virginia
☐ MA	Massachusetts	☐ VI	U.S. Virgin Islands
☐ MD	Maryland	☐ VT	Vermont
☐ ME	Maine	☐ WA	Washington
☐ MI	Michigan	☐ WI	Wisconsin
☐ MN	Minnesota	☐ WV	West Virginia
☐ MO	Missouri	☐ WY	Wyoming
☐ MS	Mississippi		

Updated: January 1, 2019

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Applicant Company Name
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

	0	1	2
<u>Admitted Assets</u>			
1. Bonds			
2. Stocks (Preferred & Common)			
3. Real Estate/Mortgage Loans on Real Estate			
4. Cash/Cash Equivalents/Short-Term Investments			
5. Other Invested Assets			
6. Aggregate Write-Ins For Invested Assets			
7. All Other Assets			
8. Total Admitted Assets (1+2+3+4+5+6+7)	<u>-</u>	<u>-</u>	<u>-</u>
<u>Liabilities</u>			
9. Losses (Unpaid Claims for Accident and Health Policies)			
10. Unpaid Claims Adjustment Expenses			
11. Aggregate Health Policy Reserves			
12. Ceded Reinsurance Premiums Payable			
13. Amounts Due To Parents, Subsidiaries & Affiliates			
14. MLR Rebates			
15. Premiums Received In Advance			
16. All Other Liabilities			
17. Total Liabilities (9+10+11+12+13+14+15+16)	<u>-</u>	<u>-</u>	<u>-</u>
<u>Capital and Surplus</u>			
18. Capital Stock			
19. Gross Paid In And Contributed Surplus			
20. Surplus Notes			
21. Unassigned Funds (Surplus)			
22. Aggregate Write-ins for Other-Than-Special Surplus Funds			
23. Less Treasury Stock (Common and Preferred)			
24. Total Capital and Surplus (18+19+20+21+22-23)	<u>-</u>	<u>-</u>	<u>-</u>
25. Liabilities and Surplus (17+24)	<u>-</u>	<u>-</u>	<u>-</u>
Risk-Based Capital Analysis			
25. Authorized Control Level Risk-Based Capital			
26. Calculated Risk-Based Capital (24/25)	<u>0.0%</u>	<u>0.0%</u>	<u>0.0%</u>

Applicant Company Name
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

	0	1	2
1. Member Months			
2. Net Premium Income			
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (L2+L3+L4+L5+L6+L7)	-	-	-
Hospital and Medical:			
9. Hospital/Medical Benefits			
10. Other Professional Services			
11. Prescription Drugs			
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (L9+L10+L11+L12)	-	-	-
Less:			
14. Net Reinsurance Recoveries			
15. Total Hospital and Medical (L13 - L14)	-	-	-
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses			
18. General Administrative Expenses			
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	-	-	-
21. Net underwriting gain or loss (L8 -L20)	-	-	-
22. Net investment income earned			
23. Net investment gains (losses) (L22+L26)	-	-	-
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred			
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (L21+L23+L24-L25)	-	-	-
29. Capital and Surplus Prior Reporting Year			
30. Net Income or (Loss)	-	-	-
31. Capital Changes			
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (L29+L30+L31+L32-L33)	-	-	-

*Itemize in Assumptions

Applicant Company Name
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Whole Numbers)

	0	1	2
Cash From Operations			
1. Premiums Collected Net of Reinsurance			
2. Net Investment Income			
3. Miscellaneous Income			
4. Benefit and Loss Related Payments			
5. Net Transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts			
6. Commissions, Expenses Paid and Aggregate Write-Ins for Deductions			
7. Dividends Paid to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered			
9. Net Cash From Operations (L1+L2+L3-L4-L5-L6-L7-L8)	-	-	-
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Miscellaneous Sources			
11. Surplus Notes, Capital Notes			
12. Capital and Paid in Surplus, Less Treasury Stock			
13. Borrowed Funds			
14. Net Deposits on Deposit-Type Contracts and Other Insurance Liabilities			
15. Dividends to Stockholders			
16. Other Cash Provided (Applied)			
17. Net Cash from Financing and Misc Sources (L11+L12+L13+L14+L15-L16)	-	-	-
18. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L17)	-	-	-

Applicant Company Name
(Health Company)
Analysis of Operations by Line of Business
(In Whole Numbers)

Nationwide

Year 1

[illegible]

Nationwide

Year 2

	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1.	Net Premium Income	-								
2.	Change in Unearned Premium Reserves and Reserve For Rate Credit	-								
3.	Fee for service	-								
4.	Risk revenue	-								
5.	Aggregate Write-Ins for Other Health Care Related Revenues	-								
6.	Aggregate Write-Ins for Other Non-Health Care Related Revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
7.	Total Revenues (1+2+3+4+5+6)	-	-	-	-	-	-	-	-	-
8.	Hospital/Medical Benefits	-								
9.	Other Professional Services	-								
10.	Prescription Drugs	-								
11.	Aggregatae Write-Ins For Other Hospital and Medical	-								
12.	Subtotal (8+9+10+11)	-	-	-	-	-	-	-	-	-
13.	Net Reinsurance Recoveries	-								
14.	Total Hospital and Medical (12-13)	-	-	-	-	-	-	-	-	-
15.	Non-Health Claims (Net)	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
16.	Claims Adjustment Expenses	-								
17.	General Administrative Expenses	-								
18.	Increase in Reserves for Accident and Health Contracts	-								
19.	Increase in Reserves for Life Contracts	-								
20.	Aggregate write in for Other Expenses	-								
21.	Total Underwriting Deductions (14 to 20)	-	-	-	-	-	-	-	-	-
22.	Net underwriting Gain or (Loss) (7-21)	-	-	-	-	-	-	-	-	-

Nationwide

Year 3

[illegible]

Applicant Company Name
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

The Nationwide page will include projected premiums by line of business for a three year period for those states in which the company is already licensed and authorized to write business and three years of projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums for the lines of business in those states in which the company is authorized to write will be pulled in from the Authorized Premium By LOB tab and the projected premiums for the lines of business in which the Applicant Company is applying for will pull in from the individual state tabs.

Nationwide
Year 1

Description	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income
1. Comprehensive (Hospital and Medical)	-	-	-	-
2. Medicare Supplement	-	-	-	-
3. Dental only	-	-	-	-
4. Vision only	-	-	-	-
5. Federal Employees Health Benefits Plan	-	-	-	-
6. Title XVIII - Medicare	-	-	-	-
7. Title XIX - Medicaid	-	-	-	-
8. Other health	-	-	-	-
9. Life	-	-	-	-
10. Property/Casualty	-	-	-	-
11. Total (L1+L2+L3+L4+L5+L6+L7+L8+L9+L10)	-	-	-	-

Nationwide
Year 2

Description	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income
1. Comprehensive (Hospital and Medical)	-	-	-	-
2. Medicare Supplement	-	-	-	-
3. Dental only	-	-	-	-
4. Vision only	-	-	-	-
5. Federal Employees Health Benefits Plan	-	-	-	-
6. Title XVIII - Medicare	-	-	-	-
7. Title XIX - Medicaid	-	-	-	-
8. Other health	-	-	-	-
9. Life	-	-	-	-
10. Property/Casualty	-	-	-	-
11. Total (L1+L2+L3+L4+L5+L6+L7+L8+L9+L10)	-	-	-	-

Nationwide
Year 3

Description	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income
1. Comprehensive (Hospital and Medical)	-	-	-	-
2. Medicare Supplement	-	-	-	-
3. Dental only	-	-	-	-
4. Vision only	-	-	-	-
5. Federal Employees Health Benefits Plan	-	-	-	-
6. Title XVIII - Medicare	-	-	-	-
7. Title XIX - Medicaid	-	-	-	-
8. Other health	-	-	-	-
9. Life	-	-	-	-
10. Property/Casualty	-	-	-	-
11. Total (L1+L2+L3+L4+L5+L6+L7+L8+L9+L10)	-	-	-	-

Applicant Company Name
(Health Company)
Authorized Premium by LOB (Aggregate) - Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Nationwide
Year 1

Description	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income
1. Comprehensive (Hospital and Medical)				-
2. Medicare Supplement				-
3. Dental only				-
4. Vision only				-
5. Federal Employees Health Benefits Plan				-
6. Title XVIII - Medicare				-
7. Title XIX - Medicaid				-
8. Other health				-
9. Life				-
10. Property/Casualty				-
11. Total (L1+L2+L3+L4+L5+L6+L7+L8+L9+L10)	-	-	-	-

Nationwide
Year 2

Description	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income
1. Comprehensive (Hospital and Medical)				-
2. Medicare Supplement				-
3. Dental only				-
4. Vision only				-
5. Federal Employees Health Benefits Plan				-
6. Title XVIII - Medicare				-
7. Title XIX - Medicaid				-
8. Other health				-
9. Life				-
10. Property/Casualty				-
11. Total (L1+L2+L3+L4+L5+L6+L7+L8+L9+L10)	-	-	-	-

Nationwide
Year 3

Description	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income
1. Comprehensive (Hospital and Medical)				-
2. Medicare Supplement				-
3. Dental only				-
4. Vision only				-
5. Federal Employees Health Benefits Plan				-
6. Title XVIII - Medicare				-
7. Title XIX - Medicaid				-
8. Other health				-
9. Life				-
10. Property/Casualty				-
11. Total (L1+L2+L3+L4+L5+L6+L7+L8+L9+L10)	-	-	-	-

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.

Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

69O-137.001 Annual and Quarterly Reporting Requirements.

(1) The purpose of this rule is to establish uniform requirements reporting of annual and quarterly statement information for all authorized insurers as defined in section 624.09, F.S.

(2) Each authorized insurer shall file with the Office a full and true statement of its financial condition, transactions, and affairs.

(a) An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 calendar days after each such date.

(b) The Office shall grant an extension of time for filing an annual or quarterly statement if there exist conditions beyond the control of the authorized insurer, such as rehabilitation pursuant to chapter 631, F.S., or the laws of the state of domicile; severe damage to the insurer's physical premises by a natural or man-made disaster; or some other reason of similar gravity and severity. The extension shall be for the amount of time reasonable to file under the conditions which justified the extension.

(c) For purposes of this rule, the requirement that statements be filed with the Office means that the statement has been transmitted electronically to the National Association of Insurance Commissioners and that the executed Jurat page of said statement has been transmitted electronically to the Office via the Regulatory Electronic Filing System, "REFS." The date affixed by the Office's electronic data processing system shall serve as evidence of the timeliness of the statement. Annual and quarterly statements in any other format shall not be submitted to the Office.

(3) Annual and Quarterly Statement Reporting.

(a) Each insurer shall submit its annual and quarterly statement information electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions specified in paragraph (3)(b), below.

(b)1. The National Association of Insurance Commissioners electronic transmission filing instructions (Financial Internet Filing Online User's Guide ~~2020 2018~~) are hereby adopted and incorporated by reference, www.flrules.org/XXXXX ~~<https://www.flrules.org/Gateway/reference.asp?No=Ref-08267>~~.

2. A copy of these specifications may be obtained from the National Association of Insurance Commissioners at http://www.naic.org/industry_financial_filing.htm.

(4) Manuals Adopted.

(a) Annual statements shall be prepared in accordance with the following manuals, which are hereby adopted and incorporated by reference:

1. The NAIC's Annual Statement Instructions, Property and Casualty, ~~2019 2017~~;
2. The NAIC's Annual Statement Instructions, Life, Accident and Health, ~~2019 2017~~;
3. The NAIC's Annual Statement Instructions, Health, ~~2019 2017~~;
4. The NAIC's Annual Statement Instructions, Title, ~~2019 2017~~; and,
5. The NAIC's Accounting Practices and Procedures Manual, as of March ~~2019 2017~~.

(b) Quarterly statements shall be prepared in accordance with the following manuals, which are hereby adopted and incorporated by reference:

1. The NAIC's Quarterly Statement Instructions, Property and Casualty, ~~2020 2018~~;
2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health, ~~2020 2018~~;
3. The NAIC's Quarterly Statement Instructions, Health, ~~2020 2018~~;
4. The NAIC's Quarterly Statement Instructions, Title, ~~2020 2018~~; and,
5. The NAIC's Accounting Practices and Procedures Manual, as of March ~~2020 2018~~.

(c) Copies of the manuals are available:

1. From the National Association of Insurance Commissioners at <http://www.naic.org>; and,
2. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.

Rulemaking Authority 624.308(1), 624.424(1) FS. Law Implemented 624.424(1) FS. History—New 3-31-92, Amended 8-24-93, 4-9-95, 4-9-97, 4-4-99, 11-30-99, 2-11-01, 4-5-01, 12-4-01, 12-25-01, 8-18-02, 7-27-03, Formerly 4-137.001, Amended 1-6-05, 9-15-05, 1-25-07, 3-16-08, 3-4-09, 1-4-10, 9-28-11, 1-28-13, 9-15-13, 7-28-15, 10-25-16, 7-30-17, 4-11-19,_____.

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2020
~~2018~~, is hereby adopted and incorporated by reference.

(b) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2019
~~2017~~, is hereby adopted and incorporated by reference.

(2) Financial examinations by the Office shall be performed in substantial conformity with the methodology outlined in the Handbook, so long as that methodology is consistent with statutory accounting principles and the Florida Insurance Code.

(3) A copy of the Examiners Handbook may be:

(a) Obtained from the National Association of Insurance Commissioners, at <http://www.naic.org>; or

(b) Inspected during regular business hours at the Office of Insurance Regulation, Larson Building, 200 E. Gaines St., Tallahassee, Florida 32399-0300.

Rulemaking Authority 624.308(1), 624.316(1)(c) FS. Law Implemented 624.316(1)(c) FS. History—New 3-30-92, Amended 4-9-97, 4-4-99, 11-30-99, 2-11-01, 12-25-01, 8-18-02, 7-27-03, Formerly 4-138.001, Amended 1-6-05, 9-15-05, 1-25-07, 3-16-08, 3-4-09, 1-4-10, 11-2-11, 1-28-13, 9-15-13, 7-28-15, 10-25-16, 7-30-17, 4-11-19,_____.

CHAPTER 69O-144 REINSURANCE

69O-144.001	Purpose
69O-144.002	~~Approval~~ <u>Reinsurance Application Procedures</u>
69O-144.004	<u>Credit for Reinsurance: Authorized Reinsurers</u>
69O-144.005	<u>Credit for Reinsurance: Accredited Reinsurers</u>
69O-144.006	<u>Credit for Reinsurance: Reinsurers Maintaining Trust Funds</u>
69O-144.007	<u>Credit for Reinsurance ~~from~~ ~~From~~ Certified Reinsurers</u>
69O-144.009	<u>Credit for Reinsurance: Other Requirements and Provisions</u>
69O-144.010	<u>Accounting Requirements: Life and Health Reinsurance Agreements</u>
69O-144.011	<u>Credit for Reinsurance from Reinsurers Domiciled in Reciprocal Jurisdictions</u>
69O-144.012	<u>Term and Universal Life Insurance Reserve Financing.</u>

69O-144.001 Purpose.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.610 FS. History—New 1-30-91, Formerly 4-108.001, Amended 5-12-94, Formerly 4-144-001, Repealed.

69O-144.002 ~~Approval~~ Reinsurance Application Procedures.

Substantial rewording of rule 69O-144.002, F.A.C., follows. See Florida Administrative Code for present text.

(1) Filing requirements and costs.

(a) Insurers making the required filings under the provisions of section 624.610, F.S., and the rules of this chapter shall submit such filings electronically to the Office at www.flair.com/iportal.

1. Application filings shall be submitted to the Office's Company Admissions System, "iApply."

2. Other annual, quarterly, or requested filings shall be submitted to the Office's Regulatory Electronic Filing System, "REFS."

(b) The costs and expenses incurred by the Office to review an application for, and subsequent reviews of accredited reinsurer status under section 624.610, F.S., and the rules of this chapter shall be charged to and collected from the applicant assuming insurer. Costs are defined as the sum of the time spent by Office personnel calculated at payroll rates inclusive of personnel benefit expenses and overhead expenses for each Office employee, and other Office expenses related to processing the application; or, the actual charges incurred by a third party retained to assist in the Office's review of the application.

1. Should it become necessary to hire an outside consultant in the process of the review, the insurer shall be contacted in advance to consent to this and agree to the cost. In the event that the Office and the insurer agree to utilize the services of an outside consultant to conduct the review, the following applies:

a. The acceptability of a person or firm to the Office shall be determined based on consideration of the person or firm's professional competence, objectivity, and cost.

b. Consent of the insurer shall be demonstrated by written confirmation from an officer of the insurer agreeing to an examination or the specific services to be performed by the person or firm, and acknowledgment that the person or firm is acceptable to the insurer and that the cost will be paid by the applicant.

c. All payments for services under this provision shall be made directly to the person or firm in accordance with the rates and terms agreed to by the Office, the insurer, and the person or firm performing the examination.

(c) Failure to pay the assessed costs under paragraph (b) may be grounds for revocation of the insurer's application or accreditation, pursuant to section 624.610, F.S.

(2)(a) An assuming insurer seeking accredited reinsurer status in this state, pursuant to section 624.610(3), F.S. and rule 69O-144.005, F.A.C., shall file an application in compliance with the directions in Form OIR-C1-923, "Application for Accredited Reinsurer Status," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX. The insurer shall further submit, or otherwise comply with, the following:

1. Form OIR-A1-2116, "Form C Summary of Changes to Registration Statement," effective 9/21, is hereby incorporated by reference and available at www.flrules.org/XXXXX;

2. Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," effective 9/21, is hereby incorporated by reference and available at www.flrules.org/XXXXX;

3. Form OIR-C1-938, "Fingerprint Payment and Submission Procedure," effective 6/20, is hereby incorporated by reference and available at www.flrules.org/XXXXX;

4. Form OIR-C1-1423, "Uniform Certificate of Authority Application (UCAA) Biographical Affidavit," effective 9/21, is hereby incorporated by reference and available at www.flrules.org/XXXXX;

5. Form OIR-C1-1464, "Florida Certificate of Assuming Insurer," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX, as required by rule 69O-144.005(2)(a), F.A.C.;

6. Form OIR-C1-1524, "Uniform Certificate of Authority Application (UCAA) Uniform Consent to Service of Process," effective 12/19, is hereby incorporated by reference and available at www.flrules.org/XXXXX;

7. Form OIR-D0-516, "Form B Insurance Holding Company System Registration Statement," effective 9/21, is hereby incorporated by reference and available at www.flrules.org/XXXXX; and,

8. Form OIR-C1-2221, "Management Information Form," effective 6/20, is hereby incorporated by reference and available at www.flrules.org/XXXXX.

(b) An assuming insurer seeking to maintain its accredited reinsurer status in this state, pursuant to rule 69O-144.005(2)(c), F.A.C., shall submit the following:

1. Annually, a copy of its annual statements prepared in accordance with the National Association of Insurance Commissioners (NAIC) manuals adopted in rule 69O-137.001, F.A.C., as filed with the insurance regulator of the assuming insurer's state of domicile or, in the case of a U.S. branch of an alien assuming insurer, as filed with the state through which it is entered and in which it is licensed to transact insurance or reinsurance;

2. If quarterly statements are required by the assuming insurer's state of domicile, or if quarterly statements are not required by the state of domicile but the Office makes a written request of them from the assuming insurer: then quarterly, a copy of the assuming insurer's quarterly statements prepared in accordance with the NAIC manuals adopted in rule 69O-137.001, F.A.C., with the insurance regulator of the assuming insurer's state of domicile or, in the case of a U.S. branch of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance; and,

3. Annually, a copy of the assuming insurer's most recent audited financial statement.

(3)(a) An assuming insurer seeking trustee reinsurer status in this state, pursuant to section 624.610(3)(c), F.S. and rule 69O-144.006(1)(a)1., F.A.C., shall file an application in compliance with the directions in Form OIR-C1-1466, "Application for Trustee Reinsurer Status," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX. The insurer shall further submit, or otherwise comply with, the following:

1. A copy of its annual statement with information substantially the same as that required to be reported in the NAIC Annual Statement form by authorized insurers, as incorporated by reference in rule 69O-137.001, F.A.C., in the same format required by such form and including all supporting documents;

2. A certified copy of the trust agreement and any trust amendments, including an approval from the insurance regulator of the state in which the trust is domiciled or of the insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust;

3. A statement from the trustee of the trust to the insurance regulator having regulatory oversight of the trust certifying the balance of the trust and the trust's investments at the preceding year end with certification that the trust will not expire prior to the following December 31;

4. Form OIR-C1-1423, incorporated by reference in subsection (1);

5. Form OIR-C1-1469, "Certificate of Assuming Insurer to Submit to Examination and Bear the Cost of Examination," effective 9/21, is hereby incorporated by reference and available at www.flrules.org/XXXXX;

6. Form OIR-C1-1524, incorporated by reference in subsection (1);

7. Form OIR-C1-2221, incorporated by reference in subsection (1); and,

8. Any other information required by section 624.610(3), F.S., or rule 69O-144.006(1), F.A.C.

(b) An assuming insurer seeking to maintain its trustee reinsurer status in this state, pursuant to section 624.610(3)(c), F.S., and rule 69O-144.006(1)(a)2., F.A.C., shall:

1. File annually with the Office substantially the same information as that required to be reported on the NAIC Annual Statement form by authorized insurers, which is incorporated in rule 69O-137.001, F.A.C., to enable the Office to determine the sufficiency of the trust fund; and,

2. Comply with the ongoing requirements in rule 69O-144.006(1), F.A.C.

(4)(a) An assuming insurer seeking certified reinsurer status in this state, pursuant to section 624.610(3), F.S. and rule 69O-144.007(8)(a), F.A.C., shall file an application in compliance with the directions in Form OIR-C1-996, "Application for Certified Reinsurer Status," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX. The insurer shall further submit, or otherwise comply with, the following:

1. Audited annual financial statements for the last two (2) years, as filed with the assuming insurer's domiciliary jurisdiction;

2. The report(s) of the independent auditor for the financial statements of the assuming insurer's insurance enterprise from the last two (2) years, as filed with the assuming insurer's domiciliary jurisdiction;

3. The most recent actuarial opinion as filed with the assuming insurer's domiciliary jurisdiction;
 4. Form OIR-C1-2116, "Certificate of Certified Reinsurer," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX, as required by rule 69O-144.007(8)(a)4., F.A.C.;
 5. Form OIR-C1-2117, "NAIC Form CR-F" (for property/casualty), effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX, or Form OIR-C1-2118, "NAIC Form CR-S" (for life and health), effective 9/21, which is hereby incorporated by reference and available at <https://www.flrules.org/XXXXX>;
 6. A list of all disputed or overdue recoverables due to or claimed by ceding insurers, whether or not the claims are in litigation or arbitration;
 7. A certification from the domiciliary jurisdiction of the assuming insurer that the insurer is in good standing with that jurisdiction and that the insurer maintains capital in excess of the jurisdiction's highest regulatory action level;
 8. Form OIR-C1-1416, "Uniform Certificate of Authority Application (UCAA) Lines of Insurance," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX;
 9. Form OIR-C1-1524, incorporated by reference in subsection (1);
 10. Form OIR-C1-2221, incorporated by reference in subsection (1); and,
 11. Any other information that the Office reasonably requires to evaluate the application, including any information required by rule 69O-144.007(8)(a), F.A.C.
- (b) An assuming insurer seeking to maintain its certified reinsurer status in this state, pursuant to section 624.610(3), F.S., and rule 69O-144.007(8)(h), F.A.C., shall annually submit the following, no later than July 1:
1. Form OIR-C1-2117, "NAIC Form CR-F" (for property/casualty), or Form OIR-C1-2118, "NAIC Form CR-S" (for life and health), both of which are incorporated in paragraph (3)(a) of this rule;
 2. The assuming insurer's most recent audited financial statements, as filed with its domiciliary jurisdiction;
 3. The report(s) of the independent auditor for the most recent financial statements of the assuming insurer's insurance enterprise, as filed with the assuming insurer's domiciliary jurisdiction;
 4. The most recent actuarial opinion as filed with the assuming insurer's domiciliary jurisdiction;
 5. A statement from the assuming insurer's domiciliary jurisdiction that the assuming insurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level;
 6. A statement certifying that there has been no change in the provisions of the assuming insurer's domiciliary license or any of its financial strength ratings, or a statement describing such changes and the reasons therefore;
 7. Any change in the assuming insurer's directors and officers;
 8. An updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from ceding insurers; and,
 9. Any other information that the Office reasonably requires to evaluate the assuming insurer's status, including any information required by rule 69O-144.007(8)(h), F.A.C.
- (c) If an NAIC accredited jurisdiction has determined that a certified reinsurer has met the conditions in that jurisdiction to become a certified reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the certified reinsurer's status in this state.
- (5)(a) An assuming insurer seeking reciprocal jurisdiction reinsurer status in this state, pursuant to section 624.610(4), F.S., and rule 69O-144.011(3)(e), F.A.C., shall, on behalf of itself and any legal predecessors, file an application in compliance with the directions in Form OIR-C1-518, "Application for Reciprocal Jurisdiction Reinsurer Status," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX. The insurer shall further submit, or otherwise comply with, the following:
1. Form OIR-C1-517, "Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction," effective 9/21, which is hereby incorporated by reference and available at www.flrules.org/XXXXX, as required by rule 69O-144.011(3)(d), F.A.C.;
 2. Written confirmation from the assuming insurer's reciprocal jurisdiction that as of the preceding December 31 or as of the most recent date otherwise statutorily reported to the jurisdiction, the assuming insurer has complied with the requirements set forth in rules 69O-144.011(3)(b) and (3)(c), F.A.C.;
 3. For the two (2) years preceding entry into the reinsurance agreement, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the assuming insurer's reciprocal jurisdiction, including the external audit report;
 4. For the two (2) years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;

5. Prior to entry into the reinsurance agreement, a current list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States;

6. Prior to entry into the reinsurance agreement, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in rule 69O-144.011(3)(f), F.A.C.;

7. Form OIR-C1-1524, incorporated by reference in subsection (1);

8. Form OIR-C1-2221, incorporated by reference in subsection (1); and,

9. Any other information required or requested by the Office, pursuant to section 624.610(4), F.S., or rule 69O-144.011(3), F.A.C.

(b) An assuming insurer seeking to maintain its reciprocal jurisdiction reinsurer status in this state, pursuant to section 624.610(4), F.S., and rule 69O-144.011(3)(g), F.A.C., shall annually submit the following, no later than each July 1:

1. Written confirmation from the assuming insurer's reciprocal jurisdiction that as of the preceding December 31 or as of the annual date otherwise statutorily reported to the jurisdiction, the assuming insurer complies with the requirements set forth in rules 69O-144.011(3)(b) and (3)(c), F.A.C.;

2. The assuming insurer's most recent audited financial statements, in accordance with the applicable law of the assuming insurer's reciprocal jurisdiction, including the external audit report;

3. The assuming insurer's most recent solvency and financial condition report or actuarial opinion, if filed with its supervisor;

4. An updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States;

5. Information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer, to allow for the evaluation of the criteria set forth in rule 69O-144.011(3)(f), F.A.C.; and,

6. Any other information required or requested by the Office, pursuant to section 624.610(4), F.S., or rule 69O-144.011(3)(g), F.A.C.

(c) If an NAIC accredited jurisdiction has determined that a reciprocal jurisdiction reinsurer has met the conditions in that jurisdiction to become a reciprocal jurisdiction reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the reciprocal jurisdiction reinsurer's status in this state.

(d) This subsection does not limit the authority of the Office to request additional information pertaining to the reinsurance agreement, or any subsequent reinsurance agreement entered into by the assuming insurer and Florida ceding insurers, under section 624.610(4)(e), F.S.

(6) An assuming insurer meeting any other eligibility criteria under the rules of this chapter or under section 624.610, F.S., shall make the necessary and applicable filings with the Office.

Rulemaking Authority 624.308, 624.610(15)(44) FS. Law Implemented 624.307(1), (2), (3), (5), 624.316, 624.317, 624.318, 624.321, 624.324, 624.34, 624.401, 624.404, 624.407, 624.413, 624.424, 624.501(20), 624.5091, 624.610, 628.051, 628.061, 628.801, 629.081 FS. History—New 1-30-91, Formerly 4-108.002, Amended 5-12-94, 10-13-02, Formerly 4-144-002, Amended 9-14-06,_____.

69O-144.004 Credit for Reinsurance: Authorized Reinsurers.

(1) Credit for reinsurance by a domestic insurer shall be allowed when the reinsurance is ceded to an assuming insurer that is authorized to transact that line of insurance or reinsurance both in this state and its state, place, or country of domicile as of the ceding insurer's statutory financial statement, pursuant to section 624.610(3)(a), F.S.

(2) An assuming insurer seeking to apply for and/or maintain authorized reinsurer status in this state shall comply with the applicable portions of this chapter and the Florida Insurance Code.

Rulemaking Authority 624.308(1), 624.610(15) FS. Law Implemented 624.307(1), 624.610 FS. History—New _____.

69O-144.005 Credit for Reinsurance: Accredited Reinsurers.

Substantial rewording of rule 69O-144.005 follows. See Florida Administrative Code for present text.

(1) Credit for reinsurance by a domestic insurer shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state pursuant to section 624.610(3)(b), F.S., and the rules of this chapter, as of any date on which statutory financial statement credit for reinsurance is claimed.

(2) Application and documentation requirements. An assuming insurer seeking accredited reinsurer status in this state pursuant to section 624.610(3)(b), F.S., must file an application with the Office in accordance with rule 69O-144.002(2)(a), F.A.C. The application must include documentation that the assuming insurer:

(a) Submits to this state's jurisdiction and to this state's authority to examine its books and records, via a properly executed Form OIR-C1-1464, "Florida Certificate of Assuming Insurer," which is incorporated by reference in rule 144.002(2)(a)5.;

(b) Is licensed or authorized to transact insurance or reinsurance in at least one state; or in the case of a U.S. branch of an alien assuming insurer, is entered through at least one state, or is licensed or authorized to transact insurance or reinsurance in at least one state; and,

(c) Maintains a surplus as regards policyholders in an amount not less than \$20 million.

(3) Pursuant to section 624.610(3)(b), F.S., an assuming reinsurer that meets the requirements of subsection (2) of this rule shall be considered accredited if either:

(a) The Office approves the assuming insurer's accreditation application; or

(b) The Office does not deny the assuming insurer's accreditation application within ninety (90) days of the application date.

(4) Accreditation renewal requirements. An assuming insurer seeking to maintain its accreditation in this state must file the appropriate documentation with the Office, in accordance with rule 69O-144.002(2)(b), F.A.C.

(5) The Office shall follow the procedures and standards in section 624.610(3)(b)2., F.S., when determining whether to approve or deny the assuming insurer's application for accreditation, and when determining whether to maintain or revoke an accredited reinsurer's accreditation.

Rulemaking Authority 624.308(1), 624.610(4), (15) FS. Law Implemented 624.307(1), 624.610 FS. History—New 1-30-91, Formerly 4-108.005, Amended 12-25-97, 10-13-02, Formerly 4-144-005, Amended 9-14-06, 7-28-15.

69O-144.006 Credit for Reinsurance: Reinsurers Maintaining Trust Funds.

(1) Trusteed Reinsurers. Pursuant to section 624.610(3)(c)1., F.S., the Office shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified financial institution as defined in section 624.610(6)(b), F.S., for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest. Such reinsurers shall be referred to as "trusteed reinsurers" if approved by the Office.

(a)1. An assuming insurer seeking trusteed reinsurer status in this state, pursuant to section 624.610(3)(c), F.S., and this rule, shall file an application under the standards provided in rule 69O-144.002(3)(a), F.A.C., and in this rule.

2. An assuming insurer seeking to maintain its trusteed reinsurer status in this state shall make the additional filings required by rule 69O-144.002(3)(b), F.A.C., and shall continue to meet the applicable requirements of this rule.

(b) The following requirements apply to the following categories of assuming insurer:

1.a. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled insurers; and,

b. The assuming insurer shall maintain a trusteed surplus of not less than \$20 million, except as provided in subparagraph (1)(b)1.c. of this subsection.

c. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the insurance regulator with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount

less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

2.a. In the case of a group including incorporated and individual unincorporated underwriters, the trust fund shall consist of:

(I) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, a trustee account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group;

(II) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this rule, funds in trust in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and,

(III) In addition to these trusts, the group shall maintain a trustee surplus of which \$100 million shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.

b.(I) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(II) The group shall, within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the Office:

(A) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or

(B) If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.

(c)1.a. Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the insurance regulator of the state where the trust is domiciled or the insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust.

b. The form of the trust and any trust amendments also shall be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled.

c. The trust instrument shall provide that:

(I) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States;

(II) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's U.S. ceding insurers, their assigns and successors in interest;

(III) The trust shall be subject to examination as determined by the Office;

(IV) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and,

(V) No later than February 28 of each year, the trustee of the trust shall report to the Office in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

(VI) Any amendment to the trust shall be filed with the Office no later than thirty (30) days after approval of the amendment by the insurance regulator with principal regulatory oversight of the trust.

2.a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulator with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

b. The assets shall be distributed by and claims shall be filed with and valued by the insurance regulator with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

c. If the insurance regulator with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the insurance regulator with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

(d) For purposes of this rule, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable

to reinsurance ceded by U.S. domiciled insurers that are not otherwise secured by acceptable means, and, shall include:

1. For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:

- a. Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;
- b. Reserves for losses reported and outstanding;
- c. Reserves for losses incurred but not reported;
- d. Reserves for allocated loss expenses; and,
- e. Unearned premiums.

2. For business ceded by domestic insurers authorized to write life, health and annuity insurance:

- a. Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;
- b. Aggregate reserves for accident and health policies;
- c. Deposit funds and other liabilities without life or disability contingencies; and,
- d. Liabilities for policy and contract claims.

(e) Assets deposited in the trust and the trusteed surplus of a single assuming insurer shall consist of assets of a quality and limitation substantially similar to that required in part II of chapter 625, F.S., and shall be valued according to their fair market value.

(f) Assets deposited in the trust and the trusteed surplus of a group including incorporated and individual unincorporated underwriters established to meet the requirements of section 624.610(3)(c)3.b., F.S., shall be of the type and subject to limitations of the following:

1. Assets deposited in the trusts established pursuant to section 624.610(3)(c)3.b., F.S., and this rule shall be valued according to their fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in section 624.610(6)(a), F.S., clean irrevocable, unconditional and “evergreen” letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in section 624.610(6)(a), F.S., and investments of the type specified in this subsection.

2. Investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments.

3. No more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency.

4. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under sub-sub-subparagraph (1)(f)5.a.(V), sub-subparagraph (1)(f)5.c., sub-sub-subparagraph (1)(f)5.f.(II) or sub-subparagraph (1)(f)5.g. of this subsection.

5. The assets of a trust established to satisfy the requirements of subsection (1) shall be invested only as follows:

a. Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:

(I) The United States or by any agency or instrumentality of the United States;

(II) A state of the United States;

(III) A territory, possession or other governmental unit of the United States;

(IV) An agency or instrumentality of a governmental unit referred to in sub-subparagraphs (1)(f)5.(I) and (II) of this paragraph, if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or

(V) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

b. Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

(I) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;

(II) Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC;

or

(III) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;

c. Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

d. An investment made pursuant to the provisions of sub-subparagraphs (1)(f)5.a., b. or c. of this subsection, shall be subject to the following additional limitations:

(I) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust;

(II) An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;

(III) The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (25%) of the assets of the trust; and,

(IV) Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under sub-subparagraphs b.(I) and b.(II) of this subsection, but shall not exceed two percent (2%) of the assets of the trust.

e. As used in this chapter:

(I) "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:

(A) Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(i) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C. section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and,

(ii) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C. sections 1709 and 1715b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C. section 1703; or

(B) Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of sub-sub-subparagraphs (1)(f)5.e.(A)(i) and (A)(ii) of this subsection;

(II) "Promissory note," when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

f. Equity interests:

(I) Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:

(A) Its obligations and preferred shares, if any, are eligible as investments under this subsection; and,

(B) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. sections 78a to 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the National Association of Securities Dealers, Inc. A trust shall not invest in equity interests under this paragraph an amount exceeding one percent (1%) of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company;

(II) Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:

(A) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and,

(B) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;

(III) An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, shall not

exceed ten percent (10%) of the assets in the trust:

g. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

h. Letters of Credit.

(I) In order for a letter of credit to qualify in funding the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Office) to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(II) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and willful misconduct.

(2) Certified reinsurers involved with trust funds should refer to rule 69O-144.007(10), F.A.C. Insurers dealing with trust funds that do not meet the requirements of this rule should refer to rule 69O-144.009, F.A.C.

Rulemaking Authority 624.308(1), 624.610(4), (15) FS. Law Implemented 624.307(1), 624.610 FS. History—New

69O-144.007 Credit for Reinsurance from Certified Reinsurers.

(1) Purpose. Section 624.610(3)(e), F.S., gives the Office the option to allow credit for reinsurance without full collateral for transactions involving assuming insurers not meeting the requirements of section 624.610(3)(a), (b), (c), or (d), F.S. ~~These rules implement that subsection.~~ This rule does not apply to assuming insurers that meet the requirements of section 624.610(3)(a), (b), (c), or (d), F.S. This rule is not an attempt to assert extra-territorial jurisdiction. Insurers that write in states other than Florida will need to comply with the laws of those states.

(2) Definitions. As used in this rule the following terms have the following meanings:

~~(a) “Ceding insurer” means a domestic insurer, as defined by section 624.06(1), F.S.~~

~~(a)(b)~~ “Certified reinsurer” means an assuming insurer that may not meet the requirements of section 624.610(3)(a), (b), (c), or (d), F.S., and that has been determined by the Office ~~by order~~ to have met the requirements set forth in subsections (7) and (8) of this rule.

~~(b)(c)~~ “Qualified jurisdiction” means a jurisdiction which has met the requirements set forth in subsection (9) of this rule.

(3) Credit for reinsurance under this ~~rule section~~ shall apply only to reinsurance contracts entered into renewed or amended on or after the effective date of the certification of the assuming insurer, provided that the certified reinsurer holds surplus in excess of \$250 million and maintains a secure financial strength rating from at least two of the rating agencies indicated in ~~paragraphs (3)(a) through (c), of this subsection.~~ Due consideration shall be given to the group rating where appropriate. The credit is subject to the limitations set forth in this rule. As provided in section 624.610(3)(e), F.S., ~~acceptable~~ the rating agencies are:

(a) through (c) No change.

(d) A.M. Best Company; ~~and~~;

(e) Demotech; ~~and~~ ;

(f) Any other rating agency deemed acceptable by order of the Office. Copies of the orders issued by the Office deeming rating agencies as having experience and expertise in rating insurers doing business in Florida pursuant to section 624.610(3)(e), Florida Statutes, are located at www.flair.com/XXXXX.

(4) No change.

(5) Nothing in this rule shall be construed to deny the ceding insurer the ability to take credit for reinsurance for the remainder of its liabilities with a certified reinsurer so long as those amounts are secured with acceptable collateral pursuant to section ~~624.610(5) 624.610(4)~~, F.S., ~~and subsections 69O-144.005(5) and (6), F.A.C.~~

(6) In addition to the trust fund required under section 624.610(3)(c), F.S., the Office shall permit an assuming insurer that maintains a trust fund in a qualified U.S. financial institution, as that term is defined in section ~~624.610(6)(b) 624.610(5)(b)~~, F.S., for the payment of the valid claims of its U.S. ~~ceding cedent~~ insurers and their assigns and successors in interest to also maintain in a qualified U.S. financial institution a trust fund constituting a trusted amount at least equal to the collateral required in accordance with subsection (4) of this rule, to secure the liabilities attributable to U.S. ~~ceding cedent~~ insurers under reinsurance policies (contracts) entered into or renewed by such assuming insurer on or after the effective date of this rule or such other date as may be established in other states for ~~ceding cedent~~ insurers domiciled in such states, but only when maintenance of such a trust fund serves to protect the interests of the public and the interests of insurer solvency.

(7) A ceding insurer may not take credit pursuant to this rule unless:

(a) The assuming insurer has been determined, by order of the Office, to be ~~a~~ a certified reinsurer, pursuant to subsection (8) of this rule;

(b) The ceding insurer maintains satisfactory evidence that the ~~eligible~~ certified reinsurer meets the standards of solvency, including standards for capital adequacy, established by its domestic regulator; and,

(c) All reinsurance contracts between the ceding insurer and the certified reinsurer provide for:

1. ~~An~~ For an insolvency clause in conformance with section ~~624.610(9)~~ 624.610(8), F.S.;

2. ~~A submission to jurisdiction clause in conformance with sections 624.610(3)(f)1.a. and 2., F.S. The For a service of process clause in conformance with sections 624.610(3)(f)1. and 2., F.S.; and,~~

3. ~~A service of process clause in conformance with sections 624.610(3)(f)1.b. and 2., F.S. For a submission to jurisdiction clause in conformance with sections 624.610(3)(f)1. and 2., F.S.~~

(8) Status as certified reinsurer:

(a) An assuming insurer seeking certified reinsurer status in this state pursuant to this rule, shall file an application in accordance with rule 69O-144.002(4)(a), F.A.C., and the requirements of this rule. The application shall include written confirmation, in the form of a properly executed Form OIR-C1-2116, "Certificate of Certified Reinsurer," which is incorporated by reference in rule 69O-144.002(4)(a), F.A.C., that the assuming insurer submits to the jurisdiction of the U.S. courts, appoints the Chief Financial Officer, pursuant to section 48.151, F.S., as its agent for service of process in this state, and agrees to post one hundred percent (100%) collateral for its Florida liabilities if it resists enforcement of a valid and final judgment from a court in the United States, or if otherwise required by the Office pursuant to this rule. If an NAIC accredited jurisdiction has determined that a certified reinsurer has met the conditions in that jurisdiction to become a certified reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the certified reinsurer's status in this state.

~~Application for a determination as a certified reinsurer under this rule shall be made by cover letter from the insurer requesting a finding of certification as a reinsurer pursuant to this rule and shall be filed electronically via the Office's Online Company Admissions system, "iApply," located at <http://www.flor.com/iportal>. The cover letter shall be accompanied with the following:~~

~~1. Audited financial statements prepared on a basis for the last three (3) years as filed with the insurer's domiciliary jurisdiction. With permission of the Office, an insurer may provide audited International Financial Reporting Standards (IFRS) basis statements so long as they include an audited reconciliation of equity and net income on a U.S. GAAP basis, or, with the permission of the Office, audited IFRS statements with a reconciliation of equity and net income on a U.S. GAAP basis certified by an officer of the company;~~

~~2. An actuarial opinion as filed with the insurer's domiciliary jurisdiction;~~

~~3. Documentation, in the form of a properly executed Form OIR C1 2116, "Certificate of Certified Reinsurer," (New 6/15), which is hereby adopted and incorporated by reference <https://www.flrules.org/Gateway/reference.asp?No=Ref-05566>, that the insurer submits to the jurisdiction of the U.S. courts, appoints an agent for service of process in Florida, and agrees to post one hundred percent (100%) collateral for its Florida liabilities if it resists enforcement of a valid and final judgment from a court in the United States, or if otherwise required by the Office pursuant to this rule;~~

~~4. At the request of the Office, any other regulatory filing made with the insurer's domiciliary jurisdiction;~~

~~5. Form OIR C1 2117 <https://www.flrules.org/Gateway/reference.asp?No=Ref-05567> "NAIC Form CR F" (New 6/15) (for property/casualty) or Form OIR C1 2118 <https://www.flrules.org/gateway/reference.asp?No=Ref-05568> "NAIC Form CR S" (New 6/15) (for life and health), which are hereby adopted and incorporated by reference;~~

~~6. A list of all disputed or overdue recoverables due to or claimed by ceding insurers, whether or not the claims are in litigation or arbitration;~~

~~7. A certification from the domiciliary jurisdiction of the insurer that the company is in good standing and that the domiciliary jurisdiction will provide financial and operational information to the Office; and,~~

~~8. Any other information that the Office may reasonably deem appropriate to clarify or explain information submitted with the application.~~

(b) No change.

(c) The determination of certified reinsurer status eligibility will be made by order issued by the Office.

(d) To become a certified reinsurer, the assuming insurer, at a minimum:

1. through 2. No change.

3. Shall be domiciled in a qualified jurisdiction, as defined in subsection (9) of this rule.

(e) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters

that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

1. The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in subsection (4) of this rule. The Office shall use the lowest financial strength rating received from a rating agency indicated in subsection (3) paragraphs (3)(a)-(e) of this rule, in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies pursuant to subsection (3), will result in loss of eligibility for certification;

2. through 6. No change.

7. ~~The A~~ certified reinsurer's participation in any solvent schemes of arrangement, or similar procedure, that involves U.S. ceding insurers. ~~The A~~ certified reinsurer shall notify the Office prior to participation in any ~~a~~ solvent scheme of arrangement.

(f) through (g) No change.

(h) ~~An assuming insurer seeking to maintain its~~ Every certified reinsurer ~~status in this state~~ shall annually file the ~~following information required by rule 69O-144.002(4)(b), F.A.C. If an NAIC accredited jurisdiction has determined that a certified reinsurer has met the conditions in that jurisdiction to become a certified reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the certified reinsurer's status in this state, annually with the Office electronically via the Office's Regulatory Electronic Filing System, "REFS," located at <http://www.flor.com/iportal>, no later than July 1:~~

1. Form OIR-C1 2117, "NAIC Form CR-F," (New 6/15) (for property/casualty) or Form OIR-C1 2118, "NAIC Form CR-S," (New 6/15) (for life and health);

2. ~~The report of the independent auditor on the financial statements of the insurance enterprise, filed on a U.S. GAAP basis. If a U.S. GAAP audit is not reasonably available, the Office may allow the reinsurer to provide audited IFRS basis statements so long as a reconciliation of equity and net income are provided on a U.S. GAAP basis. The reconciliation of equity and net income to U.S. GAAP must either be audited or certified by an officer of the company;~~

3. Actuarial opinion as filed with the certified reinsurer's domiciliary jurisdiction;

4. A statement from the certified reinsurer's domiciliary jurisdiction that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level;

5. A statement certifying that there has been no change in the provisions of its domiciliary license or any of its financial strength ratings, or a statement describing such changes and the reasons therefore;

6. ~~At the request of the Office, a copy of any regulatory filings made with the certified reinsurer's domiciliary jurisdiction;~~

7. Any change in its directors and officers;

8. ~~An updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from ceding insurers; and;~~

9. ~~Any other information that the Office may require to assure market stability and the solvency of ceding insurers.~~

(i) through (k) No change.

(9) Qualified Jurisdictions. Status as a qualified jurisdiction:

(a) through (c) No change.

(d) The Office shall publish a list of a jurisdictions that have been determined to be qualified on its website.

(e) No change.

(10) A certified reinsurer shall secure obligations assumed from U.S. ceding insurers under this rule and section 624.610(3)(e), F.S., at a level consistent with its rating pursuant to subsections (3) and (4) of this rule, or by order of the Office pursuant to section 624.610(5), F.S.

(a) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security as allowed by section 624.610(5), F.S., and consistent with section 624.610(3)(e), F.S., or in a multibeneficiary trust in accordance with section 624.610(3)(c), F.S., and rule 69O-144.006, F.A.C., except as otherwise provided in this subsection.

(b) If a certified reinsurer maintains a trust to fully secure its obligations subject to section 624.610(3)(c), F.S., and rule 69O-144.006, F.A.C., and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other U.S. jurisdictions and for its obligations subject to section 624.610(3)(c), F.S., and rule 69O-144.006, F.A.C. It shall be a condition to the grant of certification under section 624.610(3)(e), F.S., and this rule, that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the insurance

regulator with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(c) The minimum trustee surplus requirements provided in section 624.610(3)(c), F.S., and rule 69O-144.006, F.A.C., are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trustee surplus of \$10 million.

(d) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the Office shall reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(e) For purposes of this subsection, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations.

1. As used in this subsection, the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

2. If the Office continues to assign a higher rating as permitted by other provisions of this rule, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

~~(11)(10)~~(a) If the rating of a certified reinsurer is below or falls below that required in subsection (4) of this rule, for the respective amount of credit, the Office shall upon written notice assign a new rating to the certified reinsurer in accordance with subsection (4) of this rule. Notwithstanding the change or withdrawal of a certified reinsurer's rating, the Office, upon a determination that the interest of ensuring market stability and the solvency of the ceding insurer requires it, shall, upon request by the ceding insurer, authorize the ceding insurer to continue to take credit for the reinsurance recoverable, or part thereof, relating to the rating change or withdrawal for some specified period of time following such change or withdrawal, unless the reinsurance recoverable is deemed uncollectible.

(b) No change.

(c) The Office shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this rule section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, would cause the Office to determine that the certified reinsurer is unwilling or unable to meet its contractual obligations.

(d) through (e) No change.

~~(12)(11)~~The ceding insurer shall give immediate notice to the Office and provide for the necessary increased reserves with respect to any reinsurance recoverables applicable, in the event:

(a) through (b) No change.

~~(13)(12)~~ The Office shall disallow all or a portion of the credit based on a review of the ceding insurer's reinsurance program, the financial condition of the certified reinsurer, the certified reinsurer's claim payment history, or any other relevant information when such action is in the best interests of market stability and the solvency of the ceding insurer. At any time, the Office may request additional information from the certified reinsurer. The failure of a certified reinsurer to cooperate with the Office is grounds for the Office to withdraw the status of the insurer as a certified reinsurer or for the disallowance or reduction of the credit granted under this rule.

~~(14)(13)~~(a) Upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer, pursuant to chapter 631, part I, F.S., or the equivalent law of another jurisdiction, a certified reinsurer, within thirty (30) days of the order, shall fund the entire amount that the ceding insurer has taken, as an asset or deduction from reserves, for reinsurance recoverable from the certified reinsurer. The insurer may request a variance and waiver from this provision as provided by section 120.542, F.S.

(b) No change.

~~(15)(14)~~ The Office may, by order, determine that credit shall not be allowed to any ceding insurer for reinsured risk pursuant to this rule if it appears to the Office that granting of the credit to the ceding insurer would not be in the public interest or serve the best interests of the ceding insurer's solvency.

~~(16)(15)~~ Nothing in this rule prohibits a ceding insurer and a reinsurer from entering into agreements establishing collateral requirements in excess of those set forth in this rule.

~~(16)~~ A ceding insurer shall notify the Office within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of assuming insurers, exceeds fifty percent (50%) of the ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

~~(17) A ceding insurer shall notify the Office within thirty (30) days after ceding to any single assuming insurer, or group of assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it is determined that the reinsurance ceded to any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the ceding insurer.~~

~~(18) All filings shall be submitted electronically to <http://www.floir.com/iportal>. Forms are available at <http://www.floir.com/iportal>.~~

Rulemaking Authority 624.308, 624.610(4), (15) (14) FS. Law Implemented 624.307(1), 624.424, 624.610 FS. History—New 10-29-08, Amended 7-28-15, 7-30-17,_____.

690-144.009 Credit for Reinsurance: Other Requirements and Provisions.

(1) Credit shall be allowed for foreign and alien insurers when the reinsurance is ceded to an assuming insurer which is domiciled or licensed in, or, in the case of a U.S. branch of an alien assuming insurer, which is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this chapter, provided the Office verifies that the assuming insurer and reinsurance agreement meet the requirements established by this chapter and section 624.610, F.S. Verification by the Office under this subsection may be made via direct review of the information that the assuming insurer has filed with the state in which it is domiciled, licensed, or entered through.

(2) Concentration risk requirements for domestic ceding insurers. The following requirements apply to all domestic ceding insurers in this state that seek to claim credit for reinsurance from assuming insurers under sections 624.610(2) through (4), F.S., or the respective rules of this chapter.

(a) A ceding insurer shall notify the Office within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of assuming insurers, exceeds fifty percent (50%) of the ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(b) A ceding insurer shall notify the Office within thirty (30) days after ceding to any single assuming insurer, or group of assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it is determined that the reinsurance ceded to any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the ceding insurer.

(3) Trust agreements qualified under section 624.610(5), F.S. The provisions of this subsection and subsection (4) concern assuming insurers that do not meet the requirements of sections 624.610(2) through (4), F.S., or the respective rules of this chapter, including rule 690-144.007, F.A.C.

(a) As used in this subsection:

1. "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

2. "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

3. "Obligations," as used in sub-subparagraphs (3)(b)1.b. and c. of this subsection, means:

a. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

b. Reserves for reinsured losses reported and outstanding;

c. Reserves for reinsured losses incurred but not reported; and,

d. Reserves for allocated reinsured loss expenses and unearned premiums.

(b) Required conditions:

1. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee, which shall be a qualified U.S. financial institution as defined in section 624.610(6)(b), F.S.

2. The trust agreement shall create a trust account into which assets shall be deposited.

3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States.

4. The trust agreement shall provide that:

a. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

b. No other statement or document is required to be presented to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

c. It is not subject to any conditions or qualifications outside of the trust agreement; and,

d. It shall not contain references to any other agreements or documents except as provided for in sub-subparagraph (3)(b)11. below.

5. The trust agreement shall be established for the sole benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

a. Receive assets and hold all assets in a safe place;

b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

d. Notify the grantor and the beneficiary within ten (10) days of any deposits to or withdrawals from the trust account;

e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and,

f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw the asset upon condition that the proceeds are paid into the trust account.

7. The trust agreement shall provide that at least thirty (30) days prior to termination of the trust account written notification of termination shall be delivered by the trustee to the beneficiary and to the Office.

8. The trust agreement shall be made subject to and be governed by the laws of the state in which the trust is domiciled.

9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

10. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and willful misconduct.

11. Notwithstanding any other provisions of this rule, when a trust agreement is established to meet the requirements of section 624.610(5), F.S., in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

a. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

b. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in sub-subparagraphs a. and b., above, as may remain executory after the withdrawal and for any period after the termination date.

12. Notwithstanding other provisions of this rule, when a trust agreement is established to meet the requirements of section 624.610(5), F.S., in conjunction with a reinsurance agreement covering life, annuities, or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

a. To pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and,

(II) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

b. To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

c. Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in a. and b. above as may remain executory after withdrawal and for any period after the termination date.

13. The reinsurance agreement may, but need not, contain the provisions required in paragraph (5)(d) of this subsection, so long as these required conditions are included in the trust agreement.

14.a. Notwithstanding any other provisions in the trust instrument, if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulator with regulatory oversight over the trust or court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight or other designated receiver all of the assets of the trust fund.

b. The assets shall be applied in accordance with the priority statutes and laws of the state in which the trust is domiciled applicable to the assets of insurance companies in liquidation.

c. If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy claims of the U.S. beneficiaries of the trust, the assets or any part of them shall be returned to the trustee for distribution in accordance with the trust agreement.

(c) Permitted conditions:

1.a. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary receive the notice.

b. The resignation or removal shall not be effective until a successor trustee has been duly appointed and approved by the beneficiary, and the grantor and all assets in the trust have been duly transferred to the new trustee.

2.a. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account.

b. Any interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in sub-subparagraph (3)(d)1.b. of this subsection.

4.a. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred.

b. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

5. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(d) A reinsurance agreement may contain provisions that stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. bank and payable in U.S. dollars, and investments permitted by part II of chapter 625, F.S., or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement.

(e) A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming

insurer in financial statements required to be filed with the Office in compliance with this chapter when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Letters of credit qualified under section 624.610(5), F.S.

(a)1. The letter of credit shall be clean, irrevocable, unconditional, and issued or confirmed by a qualified U.S. financial institution.

2. As used in this subsection, a qualified U.S. financial institution is one which meets the definition set forth in section 624.610(6)(a), F.S.

3. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented.

4. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit.

5. The letter of credit shall not contain reference to any other agreements, documents, or entities, except as provided in subparagraph (4)(f)1. of this subsection.

6.a. As used in this subsection, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.

b. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, including conservator, rehabilitator, or liquidator.

(b)1. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit.

2. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(c) The letter of credit shall contain a statement to the effect that the obligation of the qualified U.S. financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(d)1. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer.

2. The "evergreen clause" shall provide for a period of no less than sixty (60) days' notice prior to expiration date or nonrenewal.

(e)1. The letter of credit shall be subject to and governed by the laws of the state of Florida;

2. All drafts drawn on the letter of credit shall be presentable at an office in the United States of a qualified U.S. financial institution.

(f) Reinsurance agreement provisions.

1. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

a. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

b. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(I) To pay or reimburse the ceding insurer for:

(A) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies; and,

(B) The assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and,

(C) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(II) Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the specific reinsurance remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and

exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in sub-sub-subparagraph (4)(f)1.b.(I) of this subsection, as may remain after withdrawal and for any period after the termination date.

c. All of the provisions of this subparagraph (4)(f)1., shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

2. Nothing in this paragraph (4)(f), shall preclude the ceding insurer and assuming insurer from providing for:

a. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to sub-subparagraph (4)(f)1.b., above; or

b. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

Rulemaking Authority 624.308(1), 624.610(4), (15) FS. Law Implemented 624.307(1), 624.610 FS. History—New

69O-144.011 Credit for Reinsurance from Reinsurers Domiciled in Reciprocal Jurisdictions.

(1) Pursuant to section 624.610(4), F.S., the Office shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a reciprocal jurisdiction, and which meets the other requirements of the statute and this rule.

(2) As used in this chapter, a “reciprocal jurisdiction” is a jurisdiction, as designated by the Office pursuant to subsection (4) of this rule, that is one of the following:

(a) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority; or, in the case of a covered agreement between the United States and the European Union, a jurisdiction that is a member state of the European Union. As used in this rule, the term “covered agreement” has the same definition as that within section 624.610(4)(a)1., F.S.

(b) A United States jurisdiction that meets the requirements for accreditation under the Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners.

(c) A qualified jurisdiction, as defined in rule 69O-144.007(9), F.A.C., which meets the additional requirements present in section 624.610(4)(a)3., F.S.

(3) Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting each of the conditions set forth below.

(a) The assuming insurer must be licensed to transact reinsurance by, and have its head office or be domiciled in, a reciprocal jurisdiction.

(b) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in paragraph (3)(g) according to the methodology of its domiciliary jurisdiction, in the following amounts:

1. No less than \$250 million; or

2. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

a. Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least \$250 million; and

b. A central fund containing a balance of the equivalent of at least \$250 million.

(c) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:

1. If the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction as defined in section 624.610(4)(a)1., F.S., the ratio specified in the applicable covered agreement;

2. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in section 624.610(4)(a)2., F.S., a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

3. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in section 624.610(4)(a)3., F.S., after consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the Office determines to be an effective measure of solvency.

(d) The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form OIR-C1-517, “Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction,” of its agreement to the following:

1. The assuming insurer must agree to provide prompt written notice and explanation to the Office if it falls below the minimum requirements set forth in paragraphs (2)(b) or (2)(c) of this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law.

2. The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the Chief Financial Officer, pursuant to section 48.151, F.S., as its agent for service of process in this state.

a. The Office may also require that such consent be provided and included in each reinsurance agreement under the Office's jurisdiction.

b. Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

3. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

4. The assuming insurer must agree to include a provision in each reinsurance agreement requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

5. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state's ceding insurers, and agrees to notify the ceding insurer and the Office and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of sections 624.610(3) and (5), F.S., and rule 69O-144.009, F.A.C. For purposes of this rule, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's domiciliary jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's domiciliary jurisdiction.

6. The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in paragraphs (3)(e) and (3)(g) of this subsection.

(e) The assuming insurer must file an application for reciprocal jurisdiction reinsurer status, in accordance with rule 69O-144.002(5)(a), F.A.C., and the requirements of this rule. If an NAIC accredited jurisdiction has determined that a reciprocal jurisdiction reinsurer has met the conditions in that jurisdiction to become a reciprocal jurisdiction reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the reciprocal jurisdiction reinsurer's status in this state.

(f) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

1. More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the Office;

2. More than fifteen percent (15%) of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer \$100,000, or as otherwise specified in a covered agreement; or

3. The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds \$50 million, or as otherwise specified in a covered agreement.

(g) To maintain its reciprocal jurisdiction reinsurer status in this state, the assuming insurer or its legal successor must annually provide the information required by rule 69O-144.002(5)(b), F.A.C. If an NAIC accredited jurisdiction has determined that a certified reinsurer has met the conditions in that jurisdiction to become a certified reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the certified reinsurer's status in this state.

(h) Nothing in this chapter precludes an assuming insurer from providing the Office with information on a voluntary basis.

(i) The provisions of this chapter do not limit the authority of the Office to request additional information pertaining to the reinsurance agreement, or any subsequent reinsurance agreement entered into by the assuming insurer and Florida ceding insurers, under section 624.610(4)(e), F.S.

(4) The Office shall publish and maintain a list of approved reciprocal jurisdictions on its website.

(5) The Office shall publish and maintain a list of reciprocal jurisdiction reinsurers on its website.

(6) The determination of reciprocal jurisdiction reinsurer status shall be made by order issued by the Office.

(7) If the Office determines that an assuming insurer no longer meets one or more of the requirements under section 624.610, F.S., or this chapter, the Office may revoke or suspend the status of the assuming insurer.

(a) While an assuming insurer's status is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with section 624.610(5), F.S.

(b) If an assuming insurer's status is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Office and consistent with the provisions of section 624.610(4), F.S..

(8) Before denying statement credit or imposing a requirement to post security with respect to subsection (7) of this rule or adopting any similar requirement that will have substantially the same regulatory impact as security, the Office shall:

(a) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in subsection (2) of this rule;

(b) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

(c) After the expiration of 90 days or less, as set out in paragraph (8)(b), if the Office determines that no or insufficient action was taken by the assuming insurer, the Office may impose any of the requirements as set out in this subsection; and

(d) Provide a written explanation to the assuming insurer of any of the requirements set out in this subsection.

(9) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

Rulemaking Authority 624.308(1); 624.610(15). Law Implemented 624.610 FS. History-New _____.

69O-144.012 Term and Universal Life Insurance Reserve Financing.

(1) The purpose and intent of this rule is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of primary security and other security, as defined in subsection (3) of this rule, are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer:

(a) Are issued by the ceding insurer or its affiliates; or

(b) Are not unconditionally available to satisfy the general account obligations of the ceding insurer; or

(c) Create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

(2) This rule shall apply to reinsurance treaties that cede liabilities pertaining to covered policies, as that term is defined in paragraph (3)(b) of this rule, issued by any life insurance company domiciled in this state.

(3) Definitions

(a) "Actuarial method" means the methodology used to determine the required level of primary security, as described in subsection (5) of this rule.

(b) "Covered policies" means policies, other than grandfathered policies and the exemptions described in subsection (4) of this rule, of the following policy types:

1. Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or

2. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

(c) "Grandfathered policies" means policies of the types described in subparagraphs (b)1. and (b)2. of this rule that were:

1. Issued prior to January 1, 2015; and

2. Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in subsection (4) of this rule, had the rule then been in effect.

(d) "NAIC" means the National Association of Insurance Commissioners.

(e) "Non-covered policies" means any policy that does not meet the definition of covered policies, including grandfathered policies.

(f) "Required level of primary security" means the dollar amount determined by applying the actuarial method to the risks ceded with respect to covered policies, but not more than the total reserve ceded.

(g) "Primary security" means the following forms of security:

1. Cash meeting the requirements of section 624.610(5)(a), F.S.;

2. Securities listed by the NAIC Securities Valuation Office meeting the requirements of section 624.610(5)(b), F.S., but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

3. For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

a. Commercial loans in good standing of CM3 quality and higher as defined and calculated pursuant to section 624.4085(1)(m), F.S.;

b. Policy loans; and

c. Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

(h) "Other security" means any security acceptable to the office pursuant to section 625.151, F.S., other than security meeting the definition of primary security.

(i) "Valuation Manual" means the valuation manual adopted by the NAIC as defined in section 625.1212(1)(k), F.S., with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

(j) "VM-20" means "Requirements for Principle-Based Reserves for Life Products," including all relevant definitions, from the Valuation Manual defined in section 625.1212(1k).

(4) This rule does not apply to the following situations:

(a) Reinsurance of:

1. Policies that satisfy the criteria for exemption set forth in rule 69O-164.020(6)(f) or (g), F.A.C.; and which are issued before the later of:

a. The effective date of this rule, and

b. The date on which the ceding insurer begins to apply the provisions of VM-20 (as defined in subsection (3) of this rule) to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;

2. Portions of policies that satisfy the criteria for exemption set forth in rule 69O-164.020(6)(e) and which are issued before the later of:

a. The effective date of this rule, and

b. The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;

3. Any universal life policy that meets all of the following requirements:

a. Secondary guarantee period, if any, is five (5) years or less;

b. Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy as provided in section 625.121(5), F.S.; and

c. The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period;

4. Credit life insurance;

5. Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; nor

6. Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(b) Reinsurance ceded to an assuming insurer that meets the applicable requirements of section 624.610(3)(c), F.S.;

(c) Reinsurance ceded to an assuming insurer that meets the applicable requirements of sections 624.610(3)(a) or (3)(b), F.S., and that, in addition:

1. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, which are incorporated by reference in Rule 69O-137.001, F.A.C., without any departures from NAIC

statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and

2. Is not in a company action level event, regulatory action level event, authorized control level event, or mandatory control level event (as those terms are defined in section 624.4085, F.S.), when its risk-based capital ("RBC") is calculated in accordance with the life RBC report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation;

(d) Reinsurance ceded to an assuming insurer that meets the applicable requirements of sections 624.610(3)(a) or (3)(b), F.S., and that, in addition:

1. Is not an affiliate, as that term is defined in section 624.10(1), F.S., of:

a. The insurer ceding the business to the assuming insurer; or

b. Any insurer that directly or indirectly ceded the business to that ceding insurer;

2. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

3. Is both:

a. Licensed or accredited in at least 10 states (including its state of domicile), and

b. Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

4. Is not, or would not be, below 500 percent of the authorized control level RBC (as that term is defined in section 624.4085, F.S.) when its RBC is calculated in accordance with the life RBC report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus;

(e) Reinsurance ceded to an assuming insurer that:

1. Meets this state's conditions for reciprocal jurisdiction reinsurers, as set forth in section 624.610(4), F.S., and rule 69O-144.011, F.A.C.; or

2. Is certified as a reinsurer in this state, in accordance with rule 69O-144.007, F.A.C.; or

3. Maintains at least \$250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is:

a. Licensed in at least 26 states; or

b. Licensed in at least 10 states, and licensed or accredited in a total of at least 35 states;

(f) Reinsurance not otherwise exempt under paragraphs (a) through (e) if the office, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

1. The risks are clearly outside of the intent and purpose of this rule (as described in subsection (1) of this rule);

2. The risks are included within the scope of this rule only as a technicality; and

3. The application of this rule to those risks is not necessary to provide appropriate protection to policyholders.

The office shall publicly disclose any decision made pursuant to this paragraph to exempt a reinsurance treaty from this rule, as well as the general basis therefor (including a summary description of the treaty).

(5) The actuarial method

(a) Actuarial Method

The actuarial method to establish the required level of primary security for each reinsurance treaty subject to this rule shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

1. For covered policies described in subparagraph (3)(b)1. of this rule, the actuarial method is the greater of the deterministic reserve or the net premium reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the covered policies do not meet the requirements of the stochastic reserve exclusion test in the Valuation Manual, then the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR. In addition, if such covered policies are reinsured in a reinsurance treaty that also contains covered policies described in subparagraph (3)(b)2. of this rule, the ceding insurer may elect to instead use subparagraph 2. of this paragraph as the actuarial method for the entire reinsurance agreement. Whether subparagraph 1. or 2. is used, the actuarial method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

2. For covered policies described in subparagraph (3)(b)2. of this rule, the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

3. Except as provided in subparagraph 4., the actuarial method is to be applied on a gross basis to all risks with respect to the covered policies as originally issued or assumed by the ceding insurer.

4. If the reinsurance treaty cedes less than 100 percent of the risk with respect to the covered policies then the required level of primary security may be reduced as follows:

a. If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the covered policies, the required level of primary security, as well as any adjustment under sub-subparagraph c. below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

b. If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the required level of primary security may be reduced by an amount determined by applying the actuarial method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the covered policies, except that for covered policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the required level of primary security may be reduced by the statutory reserve retained by the ceding insurer on those covered policies, where the retained reserve of those covered policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

c. If a portion of the covered policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the required level of primary security may be reduced by the amount resulting by applying the actuarial method including the reinsurance section of VM-20 to the portion of the covered policy risks ceded in the exempt arrangement, except that for covered policies issued prior to January 1, 2017, this adjustment is not to exceed $[cx / (2 * \text{number of reinsurance premiums per year})]$ where cx is calculated using the same mortality table used in calculating the NPR; and

d. For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the required level of primary security.

It is possible for any combination of sub-subparagraphs a., b., c., and/or d. to apply. Such adjustments to the required level of primary security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the required level of primary security due to the cession of less than 100 percent of the risk.

The adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

5. In no event will the required level of primary security resulting from application of the actuarial method exceed the amount of statutory reserves ceded.

6. If the ceding insurer cedes risks with respect to covered policies, including any riders, in more than one reinsurance treaty subject to this rule, in no event will the aggregate required level of primary security for those reinsurance treaties be less than the required level of primary security calculated using the actuarial method as if all risks ceded in those treaties were ceded in a single treaty subject to this rule;

7. If a reinsurance treaty subject to this rule cedes risk on both covered and non-covered policies, credit for the ceded reserves shall be determined as follows:

a. The actuarial method shall be used to determine the required level of primary security for the covered policies, and subsection (6) of this rule shall be used to determine the reinsurance credit for the covered policy reserves; and

b. Credit for the non-covered policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of sub-subparagraph a., is held by or on behalf of the ceding insurer in accordance with sections 624.610(3) through (5), F.S. Any primary security used to meet the requirements of this sub-subparagraph may not be used to satisfy the required level of primary security for the covered policies.

(b) Valuation used for Purposes of Calculations

For the purposes of both calculating the required level of primary security pursuant to the actuarial method and determining the amount of primary security and other security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

1. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined

according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

2. For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken in compliance with the valuation manual defined in section 625.1212(2)(k), F.S.

(6) Requirements Applicable to covered policies to Obtain Credit for Reinsurance; Opportunity for Remediation

(a) Requirements

Subject to the exemptions described in subsection (4) of this rule and the provisions of paragraph (6)(b) of this rule, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to covered policies pursuant to sections 624.610(2) through (5), F.S., if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

1. The ceding insurer's statutory policy reserves with respect to the covered policies are established in full and in accordance with the applicable requirements of section 625.121, F.S., and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this rule does not exceed the proportionate share of those reserves ceded under the contract; and

2. The ceding insurer determines the required level of primary security with respect to each reinsurance treaty subject to this rule and provides support for its calculation as determined to be acceptable to the office; and

3. Funds consisting of primary security, in an amount at least equal to the required level of primary security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of section 624.610(5), F.S., on a funds withheld, trust, or modified coinsurance basis; and

4. Funds consisting of other security, in an amount at least equal to any portion of the statutory reserves as to which primary security is not held pursuant to subparagraph 3. above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of section 624.610(5), F.S.; and

5. Any trust used to satisfy the requirements of this subsection shall comply with all of the conditions and qualifications of section 624.610(5), F.S., except that:

a. Funds consisting of primary security or other security held in trust, shall for the purposes identified in paragraph (5)(b) of this rule, be valued according to the valuation rules set forth in that paragraph, as applicable; and

b. There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of subparagraph (a)3.; and

c. The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the primary security within the trust (when aggregated with primary security outside the trust that is held by or on behalf of the ceding insurer in the manner required by subparagraph (a)3.) below 102 percent of the level required by subparagraph (a)3. at the time of the withdrawal or substitution; and

d. The determination of reserve credit under Rule 69O-69O-144.009(3)(e), F.A.C., shall be determined according to the valuation rules set forth in paragraph (5)(b) of this rule, as applicable; and

6. The reinsurance treaty has been approved by the office.

(b) Requirements at Inception Date and on an Ongoing Basis; Remediation

1. The requirements of paragraph (6)(a) must be satisfied as of the date that risks under covered policies are ceded (if such date is on or after the effective date of this rule) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under subparagraphs (6)(a)3. or 4. with respect to any reinsurance treaty under which covered policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

2. Prior to the due date of each Quarterly or Annual Statement required by Rule 69O-137.001, F.A.C., each life insurance company that has ceded reinsurance within the scope of subsection (2) shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which covered policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of subparagraphs (6)(a)3. or 4. were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of primary security actually held pursuant to subparagraph (6)(a)3., unless either:

a. The requirements of subparagraphs (6)(a)3. or 4. were fully satisfied as of the valuation date as to such reinsurance treaty; or

b. Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of primary security and/or other security, as the case may be, in such amount and in such form as would have caused the requirements of subparagraphs (6)(a)3. or 4. to be fully satisfied as of the valuation date.

3. Nothing in subparagraph (6)(b)2. shall be construed to allow a ceding company to maintain any deficiency under subparagraphs (6)(a)3. or 4. for any period of time longer than is reasonably necessary to eliminate it.

(7) No insurer that has covered policies as to which this rule applies (as set forth in subsection (3) of this rule) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this rule, or to circumvent its purpose and intent, as set forth in subsection (1) of this rule.

Rulemaking Authority 624.308(1), 624.610(15), 625.121(3), 625.1212(5), (8). Law Implemented 624.4085, 624.610, 625.012, 625.121, 625.1212, 625.151 FS. History-New _____.

FORM C

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

By

Name of Registrant

On Behalf of Following Insurance Companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description should identify the nature of the change and shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

Name of Registrant

SIGNATURE AND CERTIFICATION

I have reviewed the above, and to the best of my knowledge, information and belief, it is true and correct.

By: _____

Print Name: _____

Title: _____

[Corporate Seal]

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20____, by _____
(name of person)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of identification produced _____

My Commission Expires _____

CERTIFICATE OF REINSURER DOMICILED IN RECIPROCAL JURISDICTION

I, _____,
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in Florida, in order to be considered for

approval in this state, hereby certify that _____ (“Assuming Insurer”):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in Florida for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. The assuming insurer agrees that it will include such consent in each reinsurance agreement, if requested by the Florida Office of Insurance Regulation (“Office”). Nothing in this paragraph constitutes or should be understood to constitute a waiver of assuming insurer’s rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.
2. Designates the Chief Financial Officer of the State of Florida as its lawful attorney in and for the state of Florida upon whom may be served any lawful process in any action, suit or proceeding in this state arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.
3. Agrees to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.
4. Agrees to provide prompt written notice and explanation if it falls below the minimum capital and surplus or capital or surplus ratio, or if any regulatory action is taken against it for serious noncompliance with applicable law.
5. Confirms that it is not presently participating in any solvent scheme of arrangement, which involves insurers domiciled in Florida. If the assuming insurer enters into such an arrangement, the assuming insurer agrees to notify the ceding insurer and the Office, and to provide 100% security to the ceding insurer consistent with the terms of the scheme.
6. Agrees that in each reinsurance agreement it will provide security in an amount equal to 100% of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final U.S. judgment, that is enforceable under the law of the territory in which it was obtained, or a properly enforceable arbitration award whether obtained by the ceding insurer or by its resolution estate, if applicable.
7. Agrees to provide the documentation in accordance with Section 624.610(4), Florida Statutes, and Rule 69O-144.008(3)(e) and (g), Florida Administrative Code, as required and/or requested by the Office.

Dated: _____

(name of assuming insurer)

BY: _____
(name of officer)

(title of officer)



Florida Office of Insurance Regulation

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in English and in searchable PDF format unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

INSTRUCTIONS

***Filing Requirements for Reciprocal Jurisdiction Reinsurer Recognized by Another NAIC-Accredited Jurisdiction**

In lieu of the entire Application for Reciprocal Jurisdiction Reinsurer Status, Applicants that have already been recognized as a reciprocal jurisdiction reinsurer in an NAIC accredited jurisdiction may instead choose to submit:

- 1) Service of Process (Section II-1),
- 2) Authorization Letter (Section II-3, if applicable), and
- 3) Documents meeting the requirements of the checklist on page 9 of this application.

SECTION I - APPLICATION

Section I-1 Application

Applicants for Reciprocal Jurisdiction Reinsurer status in Florida must submit the Checklist and Application Certification (pages 7-9) included in this form, in addition to all other documentation and forms required herein.

Section I-2 Domiciled in a Reciprocal Jurisdiction

An Applicant for status as a Reciprocal Jurisdiction Reinsurer in Florida must be licensed in, and have its head office in or be domiciled in, as applicable, a Reciprocal Jurisdiction. The Office maintains a list of current Reciprocal Jurisdictions on its website at:

<https://www.flor.com/Sections/PandC/ReciprocalJurisdictionReinsurers.aspx>

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

SECTION II - LEGAL

Section II-1 Service of Process Consent and Agreement

Provide an executed Form OIR-C1-1524, "Uniform Consent to Service of Process."

Section II-2 Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction

Complete Form OIR-C1-517, "Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction." This form must be executed by an officer of Applicant.

Section II-3 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

SECTION III – FINANCIAL

Section III-1 Minimum Capital and Surplus

Applicant must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to its Reciprocal Jurisdiction, of no less than \$250 million USD.

This requirement may also be satisfied by an association, including incorporated and individual unincorporated underwriters, having minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least \$250 million USD and a central fund containing a balance of at least \$250 million USD.

Written confirmation must be provided from its Reciprocal Jurisdiction that Applicant is in compliance with the minimum capital and surplus requirements as set forth above.

Section III-2 Minimum Solvency or Capital Ratio

Applicant must have and maintain on an ongoing basis a minimum solvency or capital ratio as follows:

- a) For Applicants qualifying pursuant to Section 624.610(4)(a)1., Florida Statutes, the ratio specified in the applicable in-force Covered Agreement where the assuming insurer is domiciled;
- b) For Applicants qualifying pursuant to Section 624.610(4)(a)2., Florida Statutes, a risk-based capital (“RBC”) ratio of 300 percent of the authorized control level calculated in accordance with Section 624.4085, Florida Statutes; or
- c) For Applicants qualifying pursuant to Section 624.610(4)(a)3., Florida Statutes, such solvency or capital ratio as determined by the Office to be an effective measure of solvency.

Written confirmation must be provided from its Reciprocal Jurisdiction that Applicant is in compliance with the minimum solvency or capital ratio requirements as set forth above.

Section III-3 Audited Financial Statements

Applicant’s annual audited financial statements for the 2 years preceding filing of this application, as filed with its Reciprocal Jurisdiction, including the external audit report.

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

Section III-4 Actuarial Opinion

The two most recent actuarial opinions, as filed with Applicant's Reciprocal Jurisdiction. If Applicant's Reciprocal Jurisdiction did not require actuarial opinions, Applicant may file solvency and financial condition reports instead.

Section III-5 List of Disputed and Overdue Claims Information

Applicant should provide a list of all disputed or overdue reinsurance claims outstanding for 90 days or more regarding reinsurance assumed from ceding insurers domiciled in the United States.

Section III-6 Prompt Payment of Claims Information

Applicant should provide information regarding assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer for the Office to evaluate the prompt payment of claims pursuant to Rule 69O-144.011(3)(f), F.A.C.

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

SECTION IV - MANAGEMENT

Section IV-1 Management Information

Submit Form OIR-C1-2221, "Management Information Form" fully describing Applicant's management and ownership. This form should include the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

CHECKLIST

Applicant Name: _____

Home Office Address: _____
(Street Address) (City)

(State/Province) (Country) (Zip Code or Equivalent)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

SECTION I - APPLICATION

- ☐ 1. Completed Checklist and Certification
- ☐ 2. Applicant is licensed in, and has its head office or is domiciled in, as applicable, a Reciprocal Jurisdiction

SECTION II – LEGAL DOCUMENTS

- ☐ 1. Uniform Consent to Service of Process (Form OIR-C1-1524)
- ☐ 2. Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction (Form OIR-C1-517)
- ☐ 3. Authorization Letter, if applicable

APPLICATION FOR RECIPROCAL JURISDICTION REINSURER STATUS

CHECKLIST

Company Name: _____

SECTION III – FINANCIAL

- ☐ 1. Written confirmation from its domiciliary jurisdiction that Applicant is in compliance with the minimum capital and surplus requirements
- ☐ 2. Written confirmation from its domiciliary jurisdiction that Applicant is in compliance with the minimum solvency or capital ratio requirements
- ☐ 3. Two years of audited financial statements as filed with Applicant's Reciprocal Jurisdiction, including the external audit reports
- ☐ 4. Two most recent actuarial opinions as filed with Applicant's Reciprocal Jurisdiction, or solvency and financial condition reports, as applicable
- ☐ 5. List of all disputed or overdue claims outstanding more 90 days or more
- ☐ 6. Prompt payment of claims information as covered in Section III-5

SECTION IV – MANAGEMENT

- ☐ 1. Completed Management Information Form (Form OIR-C1-1298)

Uniform Checklist for Reciprocal Jurisdiction Reinsurers

Reciprocal Jurisdiction Reinsurer Information:

Company Name:

Address:

Primary Contact:

Domiciliary Jurisdiction / Supervisory Authority:

Applicable Lines of Business:

I. Filing Requirements for Reciprocal Jurisdiction Reinsurer Recognized by Another NAIC-Accredited Jurisdiction

If an NAIC accredited jurisdiction has determined that a reciprocal jurisdiction reinsurer has met the conditions in that jurisdiction to become a reciprocal jurisdiction reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the reciprocal jurisdiction reinsurer's status in this state.

This does not limit the authority of the Office to request additional information pertaining to the reinsurance agreement, or any subsequent reinsurance agreement entered into by the assuming insurer and Florida ceding insurers, under section 624.610(4)(e), F.S.

Citation to State Law / Regulation	<u>Requirements</u>	Y or N	<u>Reference and Supporting Documents</u>
69O-144.002(5)(a)1., F.A.C.	Form RJ-1: An assuming insurer must submit a properly executed Form RJ-1 (OIR-C1-517, Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction) and additional information as the commissioner may require, except to the extent that they conflict with a Covered Agreement.		
69O-144.002(5)(c), F.A.C.	Lead State: If an NAIC accredited jurisdiction has determined that a reciprocal jurisdiction reinsurer has met the conditions in that jurisdiction to become a reciprocal jurisdiction reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the reciprocal jurisdiction reinsurer's status in this state.		



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

APPLICATION FOR ACCREDITED REINSURER STATUS

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in English and in searchable PDF format, unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

APPLICATION FOR ACCREDITED REINSURER STATUS

INSTRUCTIONS

SECTION I - APPLICATION FORM & FEES

Section I-1 Application Fees

Pursuant to Section 624.610(3)(b)(4), Florida Statutes, and Rule 69O-144.002(1), F.A.C, the actual costs and expenses incurred by the Office to review a reinsurer's request for accreditation must be charged to and collected from the requesting reinsurer. Should an outside consultant become necessary, the hiring and fees will be discussed with Applicant in advance as per the above.

An invoice will be provided to the reinsurer after the application has been processed.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938, "Fingerprint Payment and Submission Procedure," for instructions.

Section I-3 Application Checklist & Certification

Applicants for Accredited Reinsurer status in Florida must submit the Checklist and Application Certification (pages 8-13) included in this form, in addition to all other documentation and forms required herein. Applicant should list the lines of business (and respective code numbers) the company intends to reinsure in the state of Florida on the Application Certification page. When Accredited Reinsurer Status is granted by the Office of Insurance Regulation, it will include only those lines listed on this form. The company must be authorized in its state of domicile for the lines of business requested.

APPLICATION FOR ACCREDITED REINSURER STATUS

SECTION II - LEGAL

Section II-1 Service of Process Consent and Agreement

Provide an executed Form OIR-C1-1524, "Uniform Consent to Service of Process."

Section II-2 Certificate of Status

Submit a certificate of status dated within the last year. A certificate of status is a document issued by the public official having supervision of the records of corporations in the Applicant's home state or jurisdiction of domicile, usually the Secretary of State or equivalent office, that shows the company is duly organized in the state or jurisdiction of domicile and that all taxes and fees have been paid.

Section II-3 Attorney-in-Fact (Reciprocal Applicants Only)

Provide a copy of Applicant's power of attorney certified by the attorney-in-fact. The power of attorney submitted must comply with Sections 629.101 and 629.111, Florida Statutes.

Section II-4 Subscriber Agreement (Reciprocal Applicants Only)

Provide a copy of the subscriber agreement certified by Applicant's attorney-in-fact.

Section II-5 Appointment and Authority-of-United States Manager (Alien Applicants Only)

Provide a copy of the appointment and authority of Applicant's United States Manager certified by its officer having custody of its records. This document must be certified by the officer in the state of domicile having custody of the records.

Section II-6 Certificate of Assuming Insurer

Complete Form OIR-C1-1464, "Certificate of Assuming Insurer." This form must be executed by an officer of Applicant.

Section II-7 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent Applicant before the Office in this matter. This letter should be dated within the last year

APPLICATION FOR ACCREDITED REINSURER STATUS

SECTION III – FINANCIAL

Section III-1 Holding Company Registration Statement

Provide a Holding Company Registration Statement certified by the state of domicile if the insurer is a member of an insurance holding company system. An insurance holding company system consists of two or more affiliated persons, one or more of which is an insurer. If the insurer is not a member of an insurance holding company system, submit a statement to such fact signed by two executive officers and under the insurer's corporate seal.

Provide a copy of the SEC 10K report if the ultimate parent is required to file this report with the Federal Securities and Exchange Commission. Applicant should also provide a copy of any other audited consolidated financial statements in which it is included.

Section III-2 Annual Statement

Submit the most recent year-end annual statement on the National Association of Insurance Commissioners' ("NAIC") format. The statement must be sworn by at least two executive officers of the insurer. All schedules must be complete. Provide verification that the general interrogatories, notes to financial statements, and the Schedule Y are included as part of the annual statement.

Section III-3 Actuarial Opinion

The most recent actuarial opinion as filed with Applicant's domiciliary jurisdiction.

Section III-4 Quarterly Statements

Provide all quarterly financial statements in NAIC format covering the current year-to-date period. These statements do not have to be certified by the state of domicile, but must be signed by the company's officers and must be notarized. Supplemental loss developmental schedules (also in NAIC format) must be included for each quarter.

Section III-5 Statutorily Mandated Examination Reports

Provide the most recent report of examination performed and certified by the state of domicile. If the most recent period covered by the examination is not within three years, the Office may accept an audited certified public accountant's report for the previous two annual periods, prepared on a basis consistent with the insurance laws of the state of domicile. Reports on a consolidated basis do not meet this requirement. This must be a separate (stand-alone) audited report on Applicant or must include breakout schedules for Applicant individually.

Section III-6 Statutory Financial Statements Audited by Certified Public Accountants

Applicant must provide a copy of the latest audited certified public accountant's report on the insurer prepared on a basis consistent with the insurance laws of the insurer's state of domicile.

OIR-C1-923

Rev.: 9/21

69O-144.002

APPLICATION FOR ACCREDITED REINSURER STATUS

Section III-7 Certificate of Compliance

Submit a Certificate of Compliance. A certificate of compliance is a document issued by the public official having supervision of insurance in Applicant's state of domicile which verifies the company is duly organized and authorized to transact insurance or reinsurance and lists the lines of business it is authorized to transact. The certificate must be sealed by the insurer's state of domicile and list the lines of business the company is authorized to write.

Section III-8 Previous Florida Business History

Provide a brief history of the company since its incorporation. Include any changes of ownership or actions taken by governmental agencies that have or had jurisdiction over the insurer. Include any history that Applicant has had in withdrawing from Florida as a whole or in discontinuing a particular line of business in this state. The statement should include any parent companies or subsidiaries.

Section III-9 Certificate of Deposit (Foreign Applicants Only)

Provide an Certificate of Deposit under the seal of Applicant's state of domicile or state of entry into the United States. This is a document issued by the public official having supervision of insurance in the relevant jurisdiction showing the amount and composition of the deposit maintained by the insurer in that state.

APPLICATION FOR ACCREDITED REINSURER STATUS

SECTION IV - MANAGEMENT

Section IV-1 Management Information Forms

Submit Form OIR-C1-2221, "Management Information Form," fully describing the management, ownership, and control, direct or indirect, of the insurer up to and including any 10% or greater interest holders of the ultimate parent. A Management Information Form should be submitted for each entity in the ownership chain.

Forms should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

Section IV-2 Biographical Affidavits as to Officers, Directors, and Shareholders

Provide a copy of Form OIR-C1-1423, the "National Association of Insurance Commissioners Biographical Affidavit" (NAIC Form 11), for each individual listed in Section IV-1. Applicant may omit individuals listed for those entities in the organizational structure between the immediate parent and the ultimate parent. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

All questions must be answered. All "Yes" answers must be explained.

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

APPLICATION FOR ACCREDITED REINSURER STATUS

Section IV-3 Background Investigative Report

A Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," included in this packet.

The NAIC approved background investigation vendor list can be found at:

https://www.naic.org/documents/industry_ucaa_third_party.pdf

Section IV-4 Fingerprint Cards

Fingerprint cards must be provided to the Office for each person for whom a Biographical Affidavit is required. Please refer to Form OIR-C1-938, "Fingerprint Payment and Submission Procedure," for instructions. If an individual has submitted a fingerprint card dated within 5 years of the date of the Application filing, a fingerprint card need not be submitted for that individual.

APPLICATION FOR ACCREDITED REINSURER STATUS

CHECK LIST

SECTION I - APPLICATION FORM & FEES

Applicant Name: _____

Home Office Address: _____
(Street Address) (City)

(State/Province) (Country) (Zip Code or Equivalent)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

- ☐ 1. Fingerprint fee paid electronically
 - ☐ a. Copy of on-line payment confirmation
- ☐ 2. Application Checklist and Certification
 - ☐ a. All lines of reinsurance to be transacted listed by code number
 - ☐ b. Signed and dated by
 - ☐ i. President or Chief Executive Officer
 - ☐ ii. Secretary

APPLICATION FOR ACCREDITED REINSURER STATUS

CHECK LIST

SECTION II – LEGAL DOCUMENTS

Company Name: _____

Please check off all completed items prior to submission.

- ☐ 1. Uniform Consent to Service of Process (Form OIR-C1-1524)
- ☐ 2. Certificate of Status issued by the Florida Secretary of State evidencing registration as a foreign corporation
- ☐ 3. Attorney-in-Fact Power of Attorney (Reciprocal Applicants Only)
 - ☐ a. Power of attorney certified by applicant's attorney-in-fact
 - ☐ b. Power of attorney complies with Sections 629.101 and 629.111, Florida Statutes
- ☐ 4. Subscriber Agreement (Reciprocals Applicants Only)
 - ☐ a. Certified by attorney-in-fact
- ☐ 5. Certified Appointment and Authority by Applicant's officer
- ☐ 6. Form AR-1, Certificate of Assuming Insurer (OIR-C1-1464)
 - ☐ a. Signed and dated by the President or Chief Executive Officer
- ☐ 7. Authorization Letter (if applicable)

APPLICATION FOR ACCREDITED REINSURER STATUS

CHECK LIST

SECTION III – FINANCIAL

Company Name: _____

- ☐ **1. Holding Company Registration Statement**
- ☐ **a. Registration Provided**
- ☐ **i. Certified by state of domicile**
- or**
- ☐ **a. Statement that company is not a member of a holding company system**
- ☐ **i. Signed by two officers**
- ☐ **ii. Under corporate seal of Company**
- ☐ **b. SEC 10K report if ultimate parent is required to file with the SEC (most current year, if available)**
- ☐ **c. Audited consolidated financial statement (most current year, if available)**
- ☐ **2. Annual Statement (most current year)**
- ☐ **a. Supplemental schedules included**
- ☐ **b. Signed by two officers**
- and**
- ☐ **c. Notarized**
- or**
- ☐ **d. Certified by state of domicile**
- ☐ **3. Most recent actuarial opinion**
- ☐ **4. Quarterly Financial Statements (Supplemental Financial Statements) in NAIC format**
- ☐ **a. All statements for current year-to-date included.**

APPLICATION FOR ACCREDITED REINSURER STATUS

- ☐ b. Signed by company officers
- ☐ c. Notarized
- ☐ d. Includes supplemental loss development schedules
- ☐ 5. Most recent Statutory Examination Report (by state of domicile)
 - ☐ a. Original certification by state of domicile
 - ☐ b. Three-year period timely as to application

If over a three-year period also include:

- ☐ c. Audited certified public accountant's report (in lieu of state of domicile exam report)
- ☐ d. Under seal of state of domicile with certification letter
- ☐ 6. Statutory Financial Statements audited by Certified Public Accountant, including letter of internal control
 - ☐ a. Report provided (most current year)
- ☐ 7. Certificate of Compliance from state or country of domicile
 - ☐ a. List of lines of reinsurance authorized to transact
- ☐ 8. Previous Florida Business History statement
- ☐ 9. Certificate of Deposit (foreign reinsurer only)
 - ☐ a. Certification under seal of state of domicile
 - ☐ b. Deposited assets or securities listed

APPLICATION FOR ACCREDITED REINSURER STATUS

CHECK LIST

SECTION IV – MANAGEMENT

Company Name: _____

- ☐ 1. Management Information Forms (Form OIR-C1-2221) submitted for all required entities
- ☐ 2. Biographical affidavits (Form OIR-C1-1423) submitted for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. “Yes” answers explained
 - ☐ c. Signed
 - ☐ d. Notarized
- ☐ 3. Background investigative reports for all required individuals. The reports must be based on the Biographical Affidavits submitted to the Office with this Application.
 - ☐ a. Proof of order and confirmation of payment submitted to the Office
- ☐ 4. Fingerprint cards for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. Signed

APPLICATION FOR ACCREDITED REINSURER STATUS

APPLICATION CERTIFICATION

The below certification must be executed by two officers of applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary.

The undersigned state that they are officers having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to seek status as an Accredited Reinsurer in Florida, that they have read said application, and that they know the contents thereof and verify that the items indicated in the application checklist are true and complete to the best of their knowledge and have been submitted with the application. The undersigned represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant on behalf of which they have acted executed the instrument.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes.

By: _____ **Lines of Business** **Code Number**

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers will be accepted only if the applicant does not have these positions.

APPLICATION FOR ACCREDITED REINSURER STATUS

FLORIDA OFFICE OF INSURANCE REGULATION LINES OF BUSINESS BY COMPANY CODES

R010	Reinsurance - Fire
R020	Reinsurance - Allied Lines
R030	Reinsurance - Farmowners Multi-Peril
R040	Reinsurance - Homeowners Multi-Peril
R050	Reinsurance - Commercial Multi-Peril
R080	Reinsurance - Ocean Marine
R090	Reinsurance - Inland Marine
R100	Reinsurance - Financial Guaranty
R106	Reinsurance - Auto Warranties
R110	Reinsurance - Medical Malpractice
R120	Reinsurance - Earthquake
R160	Reinsurance - Workers' Compensation
R170	Reinsurance - Other Liability
R173	Reinsurance - Prepaid Legal
R192	Reinsurance - Private Passenger Auto Liability
R194	Reinsurance - Commercial Auto Liability
R211	Reinsurance - Private Passenger Auto Physical Damage
R212	Reinsurance - Commercial Auto Physical Damage
R220	Reinsurance - Aircraft
R230	Reinsurance – Fidelity
R240	Reinsurance - Surety
R245	Reinsurance - Bail Bonds
R250	Reinsurance - Glass
R260	Reinsurance - Burglary and Theft
R270	Reinsurance - Boiler and Machinery
R280	Reinsurance - Credit
R285	Reinsurance - Title
R290	Reinsurance - Livestock
R300	Reinsurance - Industrial Fire
R310	Reinsurance - Mortgage Guaranty
R400	Reinsurance - Ordinary Life and Annuity
R405	Reinsurance - Individual/Group Variable Annuities
R410	Reinsurance - Group Life and Annuity
R420	Reinsurance - Variable Life
**R425	Reinsurance - Fraternal Life
**R430	Reinsurance - Fraternal Health
R440	Reinsurance - Credit Life
R441	Reinsurance - Credit Disability
R450	Reinsurance - Accident and Health
R520	Reinsurance - Industrial Extended Coverage
R540	Reinsurance - Mobile Home Multi Peril
R550	Reinsurance - Mobile Home Physical Damage
R570	Reinsurance - Crop Hail
R607	Reinsurance - Home Warranties
R608	Reinsurance - Service Warranties
R610	Reinsurance - Other Warranty
R620	Reinsurance – Miscellaneous Casualty

**A Fraternal Benefit Society can cede business but can only reinsure another society as part of a merger or consolidation. [632.614, Florida Statutes]



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPrequest@floiir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail ONLY completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.



CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL

FDLE NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS FOR A CRIMINAL HISTORY RECORD CHECK

NOTICE OF:

- RETENTION OF FINGERPRINTS,
- PRIVACY POLICY, AND
- RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD

This notice is to inform you when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of the search are returned to the authorized agency ORI indicated in the transaction. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the agency from which you are seeking approval to be employed, licensed, or have access to their facility. The fingerprints submitted are retained by FDLE and the Federal Bureau of Investigation (FBI), and FDLE will notify the agency of any subsequent arrests.

Your Social Security Account Number (SSAN) is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 U.S.C. § 552a), FDLE is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. FDLE does not require a SSAN but it could cause a delay in processing your criminal history record check.

Authorized agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request a copy of your record from the screening agency. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. by calling FDLE at (850) 410-7898. If you believe the national information is in error, you may contact the FBI at (304) 625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor within a reasonable time.

The FBI's Privacy Statement follows on a separate page and contains additional information.

PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal rules providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based record checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Additional Information: The requesting agency and/or the agency conducting the application- investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch that has published notice in the Federal Register describing any systems(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).



Florida Office of Insurance Regulation

APPLICATION FOR CERTIFIED REINSURER STATUS

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in English and in searchable PDF format, unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

APPLICATION FOR CERTIFIED REINSURER STATUS

INSTRUCTIONS

***Applicants Already Certified in an NAIC Accredited Jurisdiction**

In lieu of the entire Application for Certified Reinsurer Status, Applicants that have already been certified as a reinsurer in a NAIC accredited jurisdiction may instead choose to submit:

- 1) Service of Process (Section II-1),
- 2) Authorization Letter (Section II-3, if applicable), and
- 3) Documents meeting the requirements of the checklist on pages 10-12 of this application.

SECTION I - APPLICATION FORM & FEES

Section I-1 Application

Applicants for Certified Reinsurer status in Florida must submit the Checklist (page 6-7) and Application Certification (page 8) included in this form, in addition to all other documentation and forms required herein.

Section I-2 Domiciled in a Qualified Jurisdiction

An Applicant for status as a Certified Reinsurer in Florida must be licensed and domiciled in a Qualified Jurisdiction as described in Rule 69O-144.007, F.A.C. The Office maintains a list of current Qualified Jurisdictions on its website at:

<https://www.floir.com/Sections/PandC/CertifiedReinsurers.aspx>

APPLICATION FOR CERTIFIED REINSURER STATUS

SECTION II - LEGAL

Section II-1 Service of Process Consent and Agreement

Provide an executed Form OIR-C1-1524, "Uniform Consent to Service of Process."

Section II-2 Certificate of Certified Reinsurer

Complete Form OIR-C1-2116, "Certificate of Certified Reinsurer." This form must be executed by an officer of Applicant.

Section II-3 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

APPLICATION FOR CERTIFIED REINSURER STATUS

SECTION III - FINANCIAL

Section III-1 Lines of Insurance

Submit Form OIR-C1-1416, "Uniform Certificate of Authority Application (UCAA) – Lines of Insurance," with all lines of business the reinsurer intends to reinsure. Use the Florida section and mark the lines beginning with "R" accordingly. When Certified Reinsurer Status is granted by the Office of Insurance Regulation, it will include only those lines listed on this form. The company must provide documentation that it is authorized in its state or country of domicile for the lines of business requested.

Section III-2 Domiciliary Certification

A certification from the domiciliary jurisdiction of the assuming insurer that the company is in good standing with that jurisdiction and that the insurer maintains capital in excess of the jurisdiction's highest regulatory action level.

Section III-3 Audited Financial Statements

Applicant's audited financial statements prepared on a U.S. GAAP basis for the last 2 years, as filed with the insurer's domiciliary jurisdiction.

Section III-4 Annual Auditor's Report

Annual reports of the independent auditor on the financial statements of Applicant's insurance enterprise for the last 2 years, as filed with the insurer's domiciliary jurisdiction.

Section III-5 Actuarial Opinion

The most recent actuarial opinion as filed with the insurer's domiciliary jurisdiction.

Section III-6 Financial Strength Ratings

Submit proof of a secure financial strength rating from at least two of the rating agencies approved on the Office's website at:

<https://www.flor.com/Sections/PandC/CertifiedReinsurers.aspx>

Section III-7 Assumed Reinsurance

A completed form OIR-C1-2117, "NAIC Form CR-F" (for Property & Casualty) or form OIR-C1-2118, "NAIC Form CR-S" (for Life & Health).

APPLICATION FOR CERTIFIED REINSURER STATUS

Section III-8 List of Disputed and Overdue Claims Information

Provide a list of all disputed or overdue recoverables due to or claimed by ceding insurers, whether or not the claims are in litigation or arbitration.

APPLICATION FOR CERTIFIED REINSURER STATUS

SECTION IV – MANAGEMENT

Section IV-1 Management Information

Submit Form OIR-C1-2221, “Management Information Form,” fully describing Applicant’s management and ownership. This form should include the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

APPLICATION FOR CERTIFIED REINSURER STATUS

CHECKLIST

Applicant Name: _____

Home Office Address: _____
(Street Address) (City)

(State/Province) (Country) (Zip Code or Equivalent)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

SECTION I - APPLICATION

- ☐ 1. Application Checklist (page 6-7) and Certification (page 8)
- ☐ 2. Applicant is domiciled in a Qualified Jurisdiction

SECTION II – LEGAL DOCUMENTS

- ☐ 1. Uniform Consent to Service of Process (Form OIR-C1-1524)
- ☐ 2. Certificate of Certified Reinsurer (Form OIR-C1-2116)
- ☐ 3. Authorization Letter, if applicable

APPLICATION FOR CERTIFIED REINSURER STATUS

CHECKLIST

Company Name: _____

SECTION III – FINANCIAL

- ☐ 1. Lines of Insurance, Form OIR-C1-1416
- ☐ 2. Domiciliary certification indicating that the entity is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level
- ☐ 3. Audited Financial Statements prepared on a U.S. GAAP basis, provided for last 2 years, as filed with the insurer's domiciliary jurisdiction
- ☐ 4. Annual Auditor's Report – reports from the independent auditor on the financial statements of the last 2 years, as filed with the insurer's domiciliary jurisdiction
- ☐ 5. Most recent Actuarial Opinion as filed with the insurer's domiciliary jurisdiction
- ☐ 6. Secure financial strength rating from at least two of the rating agencies approved by the Office
- ☐ 7. Assumed Reinsurance (Form OIR-C1-2117 "NAIC Form CR-F" or Form OIR-C1-2118 "NAIC Form CR-S")
- ☐ 8. List of Disputed and Overdue Claims Information

SECTION IV – MANAGEMENT

- ☐ 1. Completed Management Information Form OIR-C1-2221.

APPLICATION FOR CERTIFIED REINSURER STATUS

APPLICATION CERTIFICATION

The below certification must be executed by two officers of Applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary*.

The undersigned state that they are officers having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to seek status as a Certified Reinsurer in Florida, that they have read said application, and that they know the contents thereof and verify that the items indicated in the application checklist are true and complete to the best of their knowledge and have been submitted with the application. The undersigned represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant on behalf of which they have acted executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers will be accepted only if the applicant does not have these positions.

OIR-C1-996
Rev.: 9/21
Rule 690-144.002

Uniform Application Checklist for Certified Reinsurers

Applicant Information

Company Name:

Address:

Primary Contact:

Domiciliary Jurisdiction / Supervisory Authority:

Applicable Lines of Business:

I. Filing Requirements for Reinsurer Currently Certified by Another NAIC-Accredited Jurisdiction

If an NAIC accredited jurisdiction (“Lead state”) has determined that an applicant for certified reinsurer status has met the conditions in that jurisdiction to become a certified reinsurer, the Office may accept documentation filed with that NAIC accredited jurisdiction or with the NAIC to satisfy the certified reinsurer’s status in this state.

- a. Has the applicant been certified by an NAIC accredited jurisdiction? (Yes or No).

[If “Yes,” the Lead state will confirm that the initial or renewal certification has been reviewed by the NAIC Reinsurance Financial Analysis (E) Working Group (“ReFAWG”).]

- b. If the answer to question I.a. (above) is “No,” please complete the Application for Certified Reinsurer Status in its entirety.
- c. If the answer to question I.a. (above) is “Yes,” the applicant shall provide the information specified in the table below. In the alternative, the Commissioner may permit the applicant to provide written certification that some or all the required information was previously filed with the Lead State and the ReFAWG.

Note: The ReFAWG and the Lead State may have already collected, reviewed and approved relevant documentation such as; Biographical Affidavits, Certificates of Good Standing, Licenses, Rating Agency Reports, Reports of Auditors and other certification documents. States are encouraged to accept these prior filings as complete, in lieu of duplicative filing requests.

Citation to State Law / Regulation	<u>Requirements</u>	Y or N	<u>Reference and Supporting Documents</u>
69O-144.007(8), F.A.C.	Status of Domiciliary Jurisdiction: The applicant must be domiciled and licensed in a Qualified Jurisdiction, as determined by this state.		

Citation to State Law / Regulation	<u>Requirements</u>	Y or N	<u>Reference and Supporting Documents</u>
69O-144.002(5)(c), F.A.C.	Verification of Certification Issued by an NAIC Accredited Jurisdiction: If the applicant is requesting that the Commissioner recognize the certification issued by another NAIC accredited jurisdiction, the applicant must provide a copy of the approval letter or other documentation provided to the applicant by such NAIC accredited jurisdiction. At a minimum, this letter must confirm the following information: a. Name of state(s) in which applicant is currently certified. b. The rating and collateral percentage assigned by the accredited jurisdiction with respect to the applicant. c. The effective and expiration dates with respect to the certification. d. The lines of business to which the certification is applicable. e. The applicant's commitment to comply with all requirements necessary to maintain certification.		
69O-144.002(4)(a)11, F.A.C.	Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer: The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. If the applicant intends to utilize a multi-beneficiary trust for this purpose, the applicant must submit (1) a copy of the approval from the domiciliary regulator with regulatory oversight of the 100% collateral and reduced collateral multi-beneficiary trusts or its intention to secure the approval of the domiciliary regulator of the trust before either trust can be used. (2) the form of the trust that will be used to secure obligations incurred as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant's certified reinsurer status, i.e., the applicant's 100% collateralized trust (if applicable). The form of each trust is required to be submitted pursuant to state law in order to ensure that security for these obligations will be kept separate and to ensure that each trust meets the requirements of the state's Credit for Reinsurance statute and/or regulation.		

Citation to State Law / Regulation	<u>Requirements</u>	Y or N	<u>Reference and Supporting Documents</u>
69O-144.002(4)(a)11, F.A.C.	NOTE: <i>The MBT includes a provision that: The certified reinsurer must bind itself by the language of the multi-beneficiary trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.</i>		
69O-144.002(4)(a)4, F.A.C.	Form CR-1 (For Initial and Renewal Applications): The applicant must provide Certificate of Certified Reinsurer, Form OIR-C1-2116 (based on NAIC CR-1), which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.		
69O-144.002(4)(a)11, F.A.C.	Other Requirements: The applicant must: - Commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Failure to comply with such other requirement could disqualify the reinsurer from certification. - Provide a statement that the applicant agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.		
69O-144.007(8)(b), F.A.C.	Public Notice Requirement: The Commissioner is required to post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The Commissioner may not take final action on the application until at least 30 days after posting notice. The Commissioner will consider any comments received during the public notice period with respect to this application.		

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA) Lines of Insurance

Please complete the information below for each state in which the Applicant Company is currently licensed indicating currently authorized, currently transacting and applying for authority to do business. As a result of statutory and regulatory requirements, each state has its own terminology for the lines of insurance. The Lines of Business Matrix was developed to assist the Applicant Company in completing this form. The matrix includes each line of business as it is reported on the NAIC's annual statement blanks and corresponding state statute or regulation. The matrix is located on the UCAA website under State Charts.

ALABAMA	Authorized to Transact	Currently Transacting	Applying for
Life (Sec. 27-5-2), Annuities (Sec. 27-5-3)			
Disability (Sec. 27-5-4)			
HMO (Sec. 27-21A-1, 27-21A-2 and 27-21A-3)			
Property (Sec. 27-5-5)			
Miscellaneous Casualty (Sec. 27-5-6, 27-5-7, 27-5-8, 27-5-9)			
Title (Sec. 27-5-10)			

ALASKA	Authorized to Transact	Currently Transacting	Applying for
Life (AS 21.12.040)			
Health (AS 21.12.050)			
Disability (21.12.052)			
Annuities (AS 21.12.055)			
Variable Life (AS 21.42.370)			
Variable Annuities (AS 21.42.370)			
Property (AS 21.12.060)			
Casualty (AS 21.12.070) including clauses:			
(1) Vehicle			
(2) Liability			
(3) Workers' Compensation and Employers Liability			
(4) Burglary and Theft			
(5) Personal Property Floater			
(6) Glass			
(7) Boiler and Machinery			
(8) Leakage and Fire Extinguishing Equipment			
(9) Credit (failure of debtors to pay obligations to insured)			
(10) Malpractice			
(11) Elevator			
(12) Livestock			
(13) Entertainments			
(14) Miscellaneous			
Surety (AS 21.12.080)			
Marine (AS 21.12.090(a))			
Wet Marine and Transportation (AS 21.12.090(b))			
Mortgage Guaranty (AS 21.12.110)			
Title (AS 21.66)			
Fraternal Benefit Society (AS 21.84)			

ARIZONA	Authorized to Transact	Currently Transacting	Applying for
Casualty with Workers' Compensation A.R.S. § 20-252			
Casualty without Workers' Compensation A.R.S. § 20-252			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

ARIZONA (continued)	Authorized to Transact	Currently Transacting	Applying for
Disability A.R.S. § 20-253			
Life (Includes Annuities) A.R.S. § 20-254			
Variable Annuity A.R.S. § 20-2631(2)			
Variable Life A.R.S. § 20-2601(15)			
Marine and Transportation A.R.S. § 20-255			
Mortgage Guaranty A.R.S. § 20-1541			
Prepaid Legal A.R.S. 20-1097			
Property A.R.S. § 20-256			
Surety A.R.S. § 20-257			
Title A.R.S. § 20-1562			
Vehicle A.R.S. § 20-259			
Life & Disability Reinsurer A.R.S. § 20-1082			
Health Care Services Organization A.R.S. § 20-1051			
Health, Medical, Dental, Optometric Service Corporations A.R.S. § 20-824			
Prepaid Dental Plan Organization A.R.S. § 20-1001			
Recognized Surplus Lines A.R.S. §§ 20-407.01 & 20-409			

ARKANSAS	Authorized to Transact	Currently Transacting	Applying for
Life (ACA 23-62-102)			
Accident & Health (ACA 23-62-103)			
Property (ACA 23-62-104)			
Casualty (ACA 23-62-105)			
Surety (ACA 23-62-106)			
Workers' Compensation (ACA 23-62-105)			
Liability (ACA 23-62-105)			
Fidelity (ACA 23-62-106)			
Marine (ACA 23-62-107)			
Title (ACA 23-62-108)			
Mortgage Guaranty (ACA 23-62-110)			
Health Maintenance Organization (23-76-102)			

CALIFORNIA	Authorized to Transact	Currently Transacting	Applying for
Life (CIC 101)			
Fire (CIC 102)			
Marine (CIC 103)			
Title (CIC 104)			
Surety (CIC 105)			
Disability (CIC 106)			
Plate Glass (CIC 107)			
Liability (CIC 108)			
Workers' Compensation (CIC 109)			
Common Carrier Liability (CIC 110)			
Boiler and Machinery (CIC 111)			
Burglary (CIC 112)			
Credit (CIC 113)			
Sprinkler (CIC 114)			
Team and Vehicle (CIC 115)			
Automobile (CIC 116)			
Aircraft (CIC 118)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

CALIFORNIA (continued)	Authorized to Transact	Currently Transacting	Applying for
Mortgage Guaranty (CIC 119)			
Insolvency (119.5)			
Legal (CIC 119.6)			
Miscellaneous (CIC 120)			
Financial Guaranty (CIC 124)			

COLORADO	Authorized to Transact	Currently Transacting	Applying for
Life (10-3-102(1)(b))			
General Life			
Accident and Health			
Annuities			
Credit			
Variable Contracts			
Fraternal Benefit Society (10-14-603)			
General Life			
Accident and Health			
Annuities			
Variable Contracts			
Title (Title 10, Article 11)			
Title			
Property and Casualty (Title 10, Article 3, Sections 102(1)(a), (c) and (d) or (Title 10, Articles 12 or 13)			
General Property			
Crop			
Motor Vehicle			
General Casualty			
Accident and Health			
Fidelity and Surety (excluding bail bond)			
Bail Bond			
Workers' Compensation			
Mortgage Guaranty			
Credit			
Professional Malpractice			

CONNECTICUT	Authorized to Transact	Currently Transacting	Applying for
(C.G.S. Title 38a)			
Fire, Extended Coverage and Other Allied Lines			
Homeowners Multiple Peril			
Commercial Multiple Peril			
Earthquake			
Growing Crops			
Ocean Marine			
Inland Marine			
Accident and Health			
Workers' Compensation			
Liability other than Auto (B.I. and P.D.)			
Auto Liability (B.I. and P.D.)			
Auto Physical Damage			
Aircraft (all perils)			
Fidelity and Surety			
Financial Guaranty (mono-line)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

CONNECTICUT (continued)	Authorized to Transact	Currently Transacting	Applying for
Glass			
Burglary and Theft			
Boiler and Machinery			
Credit			
Reinsurance			
Life Non-Participating			
Life Participating			
Variable Life Non-Participating			
Variable Life Participating			
Variable Annuities			
Title			
Fraternal Benefit Societies			
Health Care Center			
Credit Life			
Credit Accident and Health			
Mortgage Guaranty (monoline)			
Residual Value			

DELAWARE	Authorized to Transact	Currently Transacting	Applying for
Life [18 Del. C. Section 902]			
Variable Annuities [Del. Reg 1]			
Variable Life [Del. Reg 44]			
Credit Life [18 Del. C. Section 902]			
Credit Health [18 Del. C. Section 903]			
Health [18 Del. C. Section 903]			
Property [18 Del. C. Section 904]			
Surety [18 Del. C. Section 905]			
Casualty [18 Del. C. Section 906(a)], including subdivisions:			
(1) Vehicle			
(2) Liability			
(3) Workers' Compensation & Employer's Liability			
(4) Burglary & Theft			
(5) Personal Property Floater			
(6) Glass			
(7) Boiler & Machinery			
(8) Leakage & Fire Extinguisher Equipment			
(9) Credit			
(10) Malpractice			
(11) Elevator			
(12) Congenital Defects			
(13) Livestock			
(14) Entertainments			
(15) Miscellaneous			
Marine & Transportation [18 Del. C. Section 907]			
Title [18 Del. C. Section 908]			

Presently, lines listed above for casualty are checked off as individual lines on the certificate of authority application form. 18 Del. C. Section 906(b) – Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under subdivisions (1) vehicle, (2) liability, (4) burglary and theft, (7) boiler and machinery, (10) malpractice and (11) elevator of subsection (a) shall for all purposes be deemed to be the same kind of insurance to which it is so incidental and shall not be subject to provisions of this title applicable to life and health insurance.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISTRICT OF COLUMBIA	Authorized to Transact	Currently Transacting	Applying for
Health Maintenance Organizations (Sec. 31 – Chapter 34)			
Life and Health			
Individual Life			
Group Life			
Variable Life (26 DCMR Chapter 27)			
Individual Accident and Health			
Group Accident and Health			
Individual Annuities (Fixed and Variable) (Sec. 31-4442)			
Group Annuities (Fixed and Variable) (Sec. 31-4442)			
Fire and Casualty			
(1) Fire (Sec. 31-2502.11)			
(2.1) Allied Lines (Sec. 31-2502.11)			
(2.2) Multiple Peril Crop			
(2.3) Federal Flood			
(2.4) Private Crop (Sec. 31-2502.11)			
(2.5) Private Flood (Sec. 31-2502.11)			
(3) Farmowners Multiple Peril (Sec. 31-2502.11)			
(4) Homeowners Multiple Peril (Sec. 31-2502.11)			
(5.1) Commercial Multiple Peril (non-liability) (Sec. 31-2502.11)			
(5.2) Commercial Multiple Peril (liability) (Sec. 31-2502.11)			
(6) Mortgage Guaranty			
(8) Ocean Marine (Sec. 31-2502.11)			
(9) Inland Marine (Sec. 31-2502.11)			
(10) Financial Guaranty			
(11) Medical Malpractice (Sec. 31-2502.11)			
(12) Earthquake (Sec. 31-2502.11)			
(13) Group Accident & Health (Sec. 31-2502.11)			
(14) Credit A&H (Group & Individual) (Sec. 31-2502.11)			
(15.1) Collectively Renewable A&H (Sec. 31-2502.11)			
(15.2) Non-cancelable A&H (Sec. 31-2502.11)			
(15.3) Guaranteed Renewable A&H (Sec. 31-2502.11)			
(15.4) Non-Renewable for Stated Reasons Only (Sec. 31-2502.11)			
(15.5) Other Accident Only (Sec. 31-2502.11)			
(15.7) All Other A&H (Sec. 31-2502.11)			
(15.8) Federal Employees Health Benefits Program			
(16) Workers' Compensation (Sec. 31-2502.11)			
(17.1) Other Liability – occurrence (Sec. 31-2502.11)			
(17.2) Other Liability – claims made (Sec. 31-2502.11)			
(18) Products Liability (Sec. 31-2502.11)			
(19.1) Private Passenger Auto No-Fault (personal injury protection) (Sec. 31-2502.11)			
(19.2) Other Private Passenger Auto Liability (Sec. 31-2502.11)			
(19.3) Commercial Auto No-Fault (personal injury protection) (Sec. 31-2502.11)			
(19.4) Other Commercial Auto Liability (Sec. 31-2502.11)			
(20) Glass (Sec. 31-2502.11)			
(21.1) Private Passenger Auto Physical Damage (Sec. 31-2502.11)			
(21.2) Commercial Auto Physical Damage (Sec. 31-2502.11)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISTRICT OF COLUMBIA (continued)	Authorized to Transact	Currently Transacting	Applying for
(22) Aircraft (all perils) (Sec. 31-2502.11)			
(23) Fidelity (Sec. 31-2502.11)			
(24) Surety (Sec. 31-2502.11)			
(26) Burglary and Theft (Sec. 31-2502.11)			
(27) Boiler and Machinery (Sec. 31-2502.11)			
(28) Credit (Sec. 31-2602.03, 31-2502.11)			
Title [Sec. 31-2602.03 (a)(7)]			

FLORIDA	Authorized to Transact	Currently Transacting	Applying for
Property & Casualty Insurers			
0010 Fire			
0020 Allied Lines			
0030 Farmowners Multi Peril			
0040 Homeowners Multi Peril			
0050 Commercial Multi Peril			
0080 Ocean Marine			
0090 Inland Marine			
0100 Financial Guaranty			
* 0106 Auto Warranties			
0110 Medical Malpractice			
0120 Earthquake			
0160 Workers' Compensation			
0170 Other Liability			
* 0173 Prepaid Legal			
0192 Private Passenger Auto Liability			
0194 Commercial Auto Liability			
0211 Private Passenger Auto Physical Damage			
0212 Commercial Auto Physical Damage			
0220 Aircraft			
0230 Fidelity			
0240 Surety			
* 0245 Bail Bonds			
0250 Glass			
0260 Burglary and Theft			
0270 Boiler and Machinery			
0280 Credit			
* 0285 Title (Title Companies Only)			
* 0290 Livestock			
0300 Industrial Fire			
* 0310 Mortgage Guaranty			
0441 Credit Disability			
* 0450 Accident and Health			
* 0520 Industrial Extended Coverage			
* 0540 Mobile Home Multi Peril			
* 0550 Mobile Home Physical Damage			
* 0570 Crop Hail			
* 0607 Home Warranties			
* 0608 Service Warranties			
* 0610 Other Warranty			
* 0620 Miscellaneous Casualty			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

FLORIDA (continued)	Authorized to Transact	Currently Transacting	Applying for
Property & Casualty Insurers (Reinsurance Only)			
R010 Fire			
R020 Allied Lines			
R030 Farmowners Multi Peril			
R040 Homeowners Multi Peril			
R050 Commercial Multi Peril			
R080 Ocean Marine			
R090 Inland Marine			
R100 Financial Guaranty			
* R106 Auto Warranties			
R110 Medical Malpractice			
R120 Earthquake			
R160 Workers' Compensation			
R170 Other Liability			
* R173 Prepaid Legal			
R192 Private Passenger Auto Liability			
R194 Commercial Auto Liability			
R211 Private Passenger Auto Physical Damage			
R212 Commercial Auto Physical Damage			
R220 Aircraft			
R230 Fidelity			
R240 Surety			
* R245 Bail Bonds			
R250 Glass			
R260 Burglary and Theft			
R270 Boiler and Machinery			
R280 Credit			
* R285 Title (Title Companies Only)			
* R290 Livestock			
R300 Industrial Fire			
* R310 Mortgage Guaranty			
R441 Credit Disability			
* R450 Accident and Health			
* R520 Industrial Extended Coverage			
* R540 Mobile Home Multi Peril			
* R550 Mobile Home Physical Damage			
* R570 Crop Hail			
* R607 Home Warranties			
* R608 Service Warranties			
* R610 Other Warranty			
* R620 Miscellaneous Casualty			
Life, Accident and Health Insurers			
0400 Ordinary Life			
Endowment			
Term Life			
Industrial Life			
Individual Annuities			
Universal Life			
0405 Individual Variable Annuities			
Group Variable Annuities			
0410 Group Life and Annuities			
0420 Variable Life			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

FLORIDA (continued)	Authorized to Transact	Currently Transacting	Applying for
0425 Fraternal Life			
0430 Fraternal Health			
0440 Credit Life			
0441 Credit Disability			
0450 Accident and Health			
R400 Reinsurance - Ordinary Life and Annuity			
R405 Reinsurance - Individual/Group Variable Annuities			
R410 Reinsurance - Group Life and Annuity			
R420 Reinsurance - Variable Life			
R440 Reinsurance - Credit Life			
R441 Reinsurance - Credit Disability			
R450 Reinsurance - Accident and Health			

* For purposes of applicant's plan of operations, these lines should be listed as "all other lines." If any are combined with other lines on the proforma (i.e. mobile home combined with homeowners), the plan of operations should specify that this was done.

GEORGIA	Authorized to Transact	Currently Transacting	Applying for
Life, accident, and sickness [O.C.G.A. § 33-3-5(1)]			
Including Variable Annuities [O.C.G.A. § 33-11-66]			
Including Variable Life [O.C.G.A. § 33-11-65]			
Fraternal [O.C.G.A. Section 33-15]			
Property, marine, and transportation [O.C.G.A. § 33-3-5(2)]			
Casualty [O.C.G.A. § 33-3-5(3)]			
Casualty Including Workers' Compensation [O.C.G.A. § 33-7-3]			
Casualty Excluding Workers' Compensation [O.C.G.A. § 33-7-3]			
Surety [O.C.G.A. § 33-3-5(4)]			
Title [O.C.G.A. § 33-3-5(5)]			
Health Maintenance Organization [O.C.G.A. § 33-3-5(6) and § 33-21-1 <i>et seq.</i>]			

HAWAII	Authorized to Transact	Currently Transacting	Applying for
Life Insurance (HRS 431:1-204)			
Including Variable Life and Variable Annuity			
Excluding Variable Life and Variable Annuity			
Accident and Health Insurance (HRS 431:1-205)			
Property Insurance (HRS 431:1-206)*			
Including Residential Hurricane (HRS 431:3-306.5)			
Excluding Residential Hurricane			
Marine and Transportation Insurance (HRS 431:1-207)			
Including Ocean Marine (HRS 431:1-211)			
Excluding Ocean Marine			
Vehicle Insurance (HRS 431:1-208)**			
General Casualty Insurance (HRS 431:1-209)* *			
Surety Insurance (HRS 431:1-210)			
Title Insurance (HRS 431:20-102)			

* (1) Concurrently licensed in General Casualty is required; (2) Residential hurricane carrier must also meet the requirements specified in Section 431:3-306.5; information required by this Section needs to be included in the application package. Failure to comply with the Section shall cause exclusion of the residential hurricane coverage.

** Local Claims and Sales Office(s) and membership of Hawaii Joint Underwriting Plan are required for all insurers authorized to write *and engage* in writing vehicle insurance.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

IDAHO	Authorized to Transact	Currently Transacting	Applying for
Life - 41-502			
Disability (Including/Excluding Managed Care) - 41-503			
Variable Annuities/Contracts – 41-502, 41-1938			
Property - 41-504			
Marine and Transportation - 41-505			
Casualty - Including Workers' Compensation - 41-506			
Casualty - Excluding Workers' Compensation - 41-506			
Surety (Including Fidelity) - 41-507			
Monoline only:			
Title - 41-508			
Mortgage Guaranty - 41-2652			

ILLINOIS	Authorized to Transact	Currently Transacting	Applying for
Class 1 Life, Accident and Health*			
(a) Life			
(b) Accident and Health			
(c) Legal Expense Insurance			
Class 2 Casualty, Fidelity and Surety*			
(a) Accident and Health			
(b) Vehicle			
(c) Liability			
(d) Workers' Compensation			
(e) Burglary and Forgery			
(f) Glass			
(g) Fidelity and Surety			
(h) Miscellaneous			
(i) Other Casualty Risks			
(j) Contingent Losses			
(k) Livestock and Domestic Animals			
(l) Legal Expense Insurance			
Class 3 Fire and Marine, etc.*			
(a) Fire			
(b) Elements			
(c) War, Riot and Explosion			
(d) Marine and Transportation			
(e) Vehicle			
(f) Property Damage, Sprinkler Leakage and Crop			
(g) Other Fire and Marine Risks			
(h) Contingent Losses			
(i) Legal Expense Insurance			
Fraternal Benefit Society			
Fraternal Benefit Society [215 ILCS 5/282.1 et seq.]			
Health Maintenance Organization			
Health Maintenance Organization (HMO) [215 ILCS 125/1-1 et seq.]			
Limited Health Service Organization			
Limited Health Service Organization (LHSO) [215 ILCS 130/1001 et seq.]			

* See 215/IL5/4 for additional description

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

INDIANA	Authorized to Transact	Currently Transacting	Applying for
Class I (Life)			
(a) Life and Annuities			
(b) Accident & Health			
(c) Variable Life and Annuities (Segregated Amounts)			
Class II (Casualty)			
(a) Accident and Health - Disability			
(b) Workers' Compensation			
(c) Burglary, Theft			
(d) Glass			
(e) Boiler and Machinery			
(f) Automobile			
(g) Sprinkler			
(h) Liability			
(i) Credit			
(j) Title			
(k) Fidelity & Surety w/Bailbonds			
(kt) Fidelity & Surety w/o Bailbonds			
(l) Miscellaneous			
(m) Legal Expenses			
Class III (Property)			
(a) Fire, Windstorm, Hail, Loot, Riot			
(b) Crops			
(c) Sprinkler			
(d) Marine			

IOWA	Authorized to Transact	Currently Transacting	Applying for
Property/Casualty Lines (515.48)			
Fire			
Extended Coverage			
Other Allied Lines			
Homeowners Multiple Peril			
Commercial Multiple Peril			
Earthquake			
Growing Crops			
Ocean Marine			
Inland Marine			
Accident and Health			
Workers' Compensation			
Other Liability			
Auto Liability			
Auto Physical Damage			
Aircraft			
Fidelity and Surety			
Glass			
Burglary and Theft			
Boiler and Machinery			
Reinsurance Only (monoline)			
Financial Guaranty (monoline)			
Life (508, 509, 511) – Life Only			
Life (508, 509, 511 and 515) credit & variable life, annuities and variable annuities and A&H			
Life (508, 509, 511 and 515) – accident and health			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Iowa (continued)	Authorized to Transact	Currently Transacting	Applying for
Reciprocal (520)			
Mortgage Guaranty (515C)			
Fraternal (512B)			

*Life includes credit life, variable life, annuities, and variable annuities.

KANSAS	Authorized to Transact	Currently Transacting	Applying for
Life (Includes Annuity and Variable Contracts)			
Accident and Health			
Stand-Alone Prescription Drug Provider			
Fire Insurance			
Fire			
Windstorm & Hail			
Extended Coverage			
Add'l. Perils on Growing Crops			
Hail on Growing Crops			
Optional Perils			
Sprinkler Leakage			
Business Interruption			
Earthquake			
Water Damage			
Aircraft Hull			
Ocean Marine			
Inland Marine			
Rain			
Automobile Physical Damage			
Flood			
Homeowners Policies			
Casualty Insurance			
Accident and Health			
Automobile Liability			
General Liability			
Workers' Compensation			
Fidelity, Surety & Forgery Bonds			
Glass			
Burglary, Theft & Robbery			
Boiler & Machinery			
Credit			
Title			
Malpractice Liability			
Livestock Mortality			
Aircraft Liability			
Cargo Liability			
Cost of Legal Services			
Mortgage Guaranty Insurance			

KENTUCKY	Authorized to Transact	Currently Transacting	Applying for
Life And Health Companies			
Life (includes variable & credit) KRS 304.5-020			
Annuity (includes variable) KRS 304.5-030			
Health (includes credit) KRS 304.5-040			
Property And Casualty Companies			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

KENTUCKY (continued)	Authorized to Transact	Currently Transacting	Applying for
Health (includes credit) KRS 304.5-040			
Property KRS 304.5-050			
Surety KRS 304.5-060			
Casualty All Lines KRS 304.5-070 (1)(a) thru (1)(q)			
Or, Casualty Limited to:			
Vehicle Insurance KRS 304.5-070(1)(a)			
Liability Insurance KRS 304.5-070(1)(b)			
Workers' Compensation and Employers Liability KRS 304.5-070(1)(c)			
Burglary and Theft KRS 304.5-070(1)(d)			
Personal Property Floater KRS 304.5-070(1)(e)			
Glass KRS 304.5-070(1)(f)			
Boiler and Machinery KRS 304.5-070(1)(g)			
Leakage and Fire Extinguishing Equipment KRS 304.5-070(1)(h)			
Credit KRS 304.5-070(1)(i)			
Malpractice KRS 304.5-070(1)(j)			
Elevator KRS 304.5-070(1)(k)			
Congenital Defects KRS 304.5-070(1)(l)			
Livestock KRS 304.5-070(1)(m)			
Entertainments KRS 304.5-070(1)(n)			
Failure of Certain Institutions to Record Documents KRS 304.5-070(o)			
Automobile Guaranty KRS 304.5-070(1)(p)			
Miscellaneous KRS 304.5-070(1)(q)			
Marine and Transportation KRS 304.5-080			
Mortgage Guaranty KRS 304.5-100			
Title KRS 304.5-090			
All Others Companies:			
Fraternal Benefit Society KRS 304.29-011			
Life			
Health			
Lloyd's KRS 304.28-010			
Non-Profit Health Service Corporation KRS 304.32-030			
Reciprocal KRS 304.27-010			

LOUISIANA*	Authorized to Transact	Currently Transacting	Applying for
Life			
Annuities			
Health and Accident			
Vehicle			
Liability			
Workers' Compensation			
Fire and Allied Lines			
Industrial Fire			
Fidelity			
Surety			
Credit Life, Health and Accident			
Credit Property and Casualty			
Marine and Transportation			
Miscellaneous			
Steam Boiler and Sprinkler Leakage			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

LOUISIANA (continued)	Authorized to Transact	Currently Transacting	Applying for
Title			
Burglary and Forgery			
Crop			
Homeowners			

*All lines of business are as defined in Louisiana Revised Statutes 22:47.

MAINE	Authorized to Transact	Currently Transacting	Applying for
Life and Health			
Life, including Credit Life and Annuities			
Health, including Credit Health			
Variable Life			
Variable Annuity			
Property & Casualty			
Fire			
Allied Lines			
Farmowners Multiple Peril			
Homeowners Multiple Peril			
Commercial Multiple Peril			
Mortgage Guaranty			
Ocean Marine			
Inland Marine			
Financial Guaranty			
Workers' Compensation			
Medical Professional Liability			
Earthquake			
Other Liability			
Product Liability			
Auto Liability			
Auto Physical Damage			
Aircraft (all perils)			
Fidelity			
Surety			
Glass			
Burglary and Theft			
Boiler and Machinery			
Credit			
Federal Flood Insurance			
Title			

MARYLAND	Authorized to Transact	Currently Transacting	Applying for
<i>Insurance Article of the Annotated Code of Maryland:</i>			
Variable Annuities – Section 1-101(d)(e), 16-601, 16-602			
Casualty (not including Vehicle Liability, Mortgage Guaranty & Workers' Compensation) – Section 1-101(i)			
Dental Plan Organization – Section 14-401			
Fraternal – 8-424			
Mortgage Guaranty – Sections 1-101(o)			
Health – Sections 1-101(p)			
Life, including Annuities and Health (except Variable Life & Variable Annuities) Sections 1-101(d), 1-101(p), 1-101(x)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MARYLAND (continued)	Authorized to Transact	Currently Transacting	Applying for
Marine, Wet Marine & Transportation – Sections 1-101(z), 1-101(ss)			
Non-Profit Health Service Plan – Section 14-110			
Property and Marine (excluding Wet Marine and Transportation) – Section 1-101(gg), 1-101(z)			
Variable Life – Sections 16-601, 16-602			
Surety – Section 1-101(oo)			
Title – Section 1-101(qq)			
Vehicle Liability – Section 1-101(i)			
Workers' Compensation – Section 1-101(i)			
<i>Health-General Article of the Annotated Code of Maryland:</i>			
Health Maintenance Organizations – Sections 19-708, 19-709, 19-710			
Provider-Sponsored Organizations – Section 19-7A			

MASSACHUSETTS	Authorized to Transact	Currently Transacting	Applying for
(M.G.L. 175 § 47)			
(1) Fire			
(2A) Ocean Marine			
(2B) Inland Marine Only			
(4) Fidelity and Surety			
(5A) Boiler, Fly Wheel, Machinery, Explosion			
(5B) Boiler (no inspector), Fly Wheel, Machinery, Explosion			
(6A) Accident - All Kinds			
(6B) Health - All Kinds			
(6C) Group Accident and Health Only			
(6D) Non-Cancelable Accident and Health Only			
(6E) Workers' Compensation			
(6F) Liability Other than Auto			
(6G) Auto Liability			
(7) Glass			
(8) Water Damage and Sprinkler Leakage			
(9) Elevator Property Damage and Collision			
(10) Credit			
(11) Title (Title Companies Only)			
(12) Burglary, Robbery, Theft, Forgery, Larceny			
(13) Livestock			
(15) Reinsurance			
(16A) Life - All Kinds			
(16B) Group Life Only			
(16C) Variable Annuity Authorization			
(16D) Annuities Only			
(16E) Variable Life Authorization			
(17) Repair - Replacement			
(19) Legal Services			
(20) Credit Involuntary Unemployment			
(51) Stock Companies Extension of Coverage- M.G.L. 175 §51(g)			
(54) Mutual Companies (specified in Section 47) - M.G.L. 175 § 54(g)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MASSACHUSETTS (continued)	Authorized to Transact	Currently Transacting	Applying for
(54BX) Reinsurance except Life - M.G.L. 175 § 54B			
(54BY) Nuclear Energy - M.G.L. 175 § 54B			
(54BZ) Special Hazards - Radioactive Contamination - M.G.L. 175 § 54B			
(54C) Comprehensive Motor Vehicle and Aircraft - M.G.L. 175 § 54C			
(54D) Personal Property Floater - M.G.L. 175 § 54D			
(54E) Dwellings - M.G.L. 175 § 54E			
(54F) Commercial Property (Multiple Peril) - M.G.L. 175 § 54F			
(54G) Reinsurance - Life Companies Only - M.G.L. 175 § 54G			

MICHIGAN	Authorized to Transact	Currently Transacting	Applying for
Life and Annuity - Other than Variable Contracts (MCL 500.602)			
Separate Account - Variable Annuities (MCL 500.925)			
Separate Account - Variable Life (MCL 500.925)			
Separate Accounts - Modified Guaranteed Annuities (MCL 500.4101)			
Disability (MCL 500.606)			
Property (MCL 500.610)			
Ocean Marine (MCL 500.614)			
Inland Marine (MCL 500.616)			
Automobile Insurance - Limited (MCL 500.620)			
Legal Expense (MCL 500.618)			
Casualty–Steam Boiler, Flywheel and Machinery (MCL 500.624(1)a)			
Casualty–Liability (MCL 500.624(1)b)			
Casualty–Automobile, including Section 500.625, disability coverage supplemental to automobile insurance (MCL 500.624(1)b)			
Casualty–Workers’ Compensation (MCL 500.624(1)b)			
Casualty–Plate Glass (MCL 500.624(1)c)			
Casualty–Sprinkler and Water Damage (MCL 500.624(1)d)			
Casualty–Credit (MCL 500.624(1)e)			
Casualty–Burglary and Theft (MCL 500.624(1)f)			
Casualty–Livestock (MCL 500.624(1)g)			
Casualty–Malpractice (MCL 500.624(1)h)			
Casualty–Miscellaneous (MCL 500.624(1)i)			
Surety and Fidelity (MCL 500.628)			
Limited Liability (MCL 500 Chapter 65)			
Title (MCL 500 Chapter 73)			
Fraternal (MCL 500 Chapter 81a)			

MINNESOTA	Authorized to Transact	Currently Transacting	Applying for
(MS 60A.06, Subd.1)			
Fire (1)			
Inland Marine (2a)			
Ocean Marine (2a)			
Personal Property Floater (2b)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MINNESOTA (continued)	Authorized to Transact	Currently Transacting	Applying for
Boiler and Machinery (3)			
Life (4)			
Variable Contract Authority (4)			
Accident and Health (5a)			
Workers' Compensation (5b)			
Fidelity (6)			
Surety (6)			
Title (7)			
Glass (8)			
Burglary & Theft (9a)			
Security and Drafts (9b)			
Personal Property Floater - Casualty (9c)			
Water (9d)			
Livestock (10)			
Credit (11)			
Automobile (12)			
General Liability (13)			
Elevator (14)			
Legal Expense (15)			

MISSISSIPPI	Authorized to Transact	Currently Transacting	Applying for
(MCA 83-19-1 Classifications of Insurance Companies)			
Class 1. Fire and Casualty			
(a) Fire and Allied Lines			
(b) Industrial Fire			
(c) Casualty/Liability			
(d) Fidelity			
(e) Surety			
(f) Workers' Compensation			
(g) Boiler and Machinery			
(h) Plate Glass			
(i) Aircraft			
(j) Inland Marine			
(k) Ocean Marine			
(l) Automobile Physical Damage/Automobile Liability			
(m) Homeowners/Farmowners			
(n) Guaranty			
(o) Mortgage Guaranty			
(p) Title			
(q) Trip Accident and Baggage			
(r) Legal			
(s) Credit Property			
Class 2. Life			
(a) Life			
(b) Accident and Health			
(c) Credit Life, Credit Accident and Health			
(d) Industrial Life, Industrial Accident and Health			
(e) Variable Contracts			
(f) Life (Burial)			
Class 3. Fraternal			
(a) Fraternal			
(b) Larger Fraternal			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

MISSISSIPPI (continued)	Authorized to Transact	Currently Transacting	Applying for
Class 4. Burial			
(MCA 83-41-303) Health Maintenance Organization			

MISSOURI	Authorized to Transact	Currently Transacting	Applying for
A – Life and Health (RSMo 376)			
A1 – Life, Annuities and Endowments (376.010)			
A2 – Accident and Health (376.010)			
A3 – Variable contracts (376.309, RSMo)			
H – Title (RSMo 381)			
B – Property and Casualty (RSMo 379)			
B1 – Property (379.010.1(1))			
B2 – Liability (379.010.1(2)) (Includes Workers' Compensation)			
B3 – Fidelity and Surety (379.010.1(3))			
B4 – Accident and Health (379.010.1(4))			
B5 – Miscellaneous (379.010.1(5))			
Health Maintenance Organization (354.400)			
Prepaid Dental Plan (354.700)			
Fraternal Benefit (378) RSMo			
Other			

MONTANA	Authorized to Transact	Currently Transacting	Applying for
Life (including variable contract authority) § 33-1-208 and 33-20-605, MCA			
Life (excluding variable contract authority) § 33-1-208, MCA			
Disability §33-1-207, MCA			
Property §33-1-210, MCA			
Casualty (including Workers' Comp) §33-1-206, MCA			
Casualty (excluding Workers' Comp) §33-1-206, MCA			
Surety §33-1-211, MCA			
Marine §33-1-209, MCA			
Title §33-1-212, MCA			

NEBRASKA	Authorized to Transact	Currently Transacting	Applying for
Life (1)			
Variable Life (2)			
Variable Annuities (3)			
Sickness & Accident (4)			
Property (5)			
Credit Property (6)			
Glass (7)			
Burglary & Theft (8)			
Boiler & Machinery (9)			
Liability (10)			
Workers' Compensation & Employers Liability (11)			
Vehicle (12)			
Fidelity (13)			
Surety (14)			
Title (15)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NEBRASKA (continued)	Authorized to Transact	Currently Transacting	Applying for
Credit (16)			
Mortgage Guaranty (17)			
Marine (18)			
Financial Guaranty (19)			
Miscellaneous (20)			

NEVADA	Authorized to Transact	Currently Transacting	Applying for
Life (681A.040)			
Health (681A.030)			
Property (681A.060)			
Casualty (681A.020) (Including Workers' Comp)			
Casualty (681A.020) (Excluding Workers' Comp)			
Surety (681A.070)			
Marine and Transportation (681A.050)			
Title (681A.080)			
Surplus Lines (685A)			
Risk Retention Group (695E)			
Funeral/Cemetery Sellers (689)			
Premium Finance Company (686A)			
Motor Clubs (696A)			
Health Maintenance Organization (695C)			
Prepaid Ltd. Health Service Organization (695F)			
Variable (688A)			
Home Protection (690B.100)			

NEW HAMPSHIRE	Authorized to Transact	Currently Transacting	Applying for
Fire and Allied Lines (RSA 401.1, I)			
Marine Coverages (RSA 401.1, II)			
Life and Annuities (RSA 401.1, III)			
Variable Annuities Require a Separate License (RSA 401.1, III)			
Accident and/or Health Coverages (401.1, IV)			
Health Maintenance Organization (RSA 402-B)			
Liability/Casualty Coverages, Including Workers' Compensation (RSA 401.1, V)			
Casualty Coverages (RSA 401.1, VI)			
Fidelity, Surety, Credit Insurance, Mortgage Guaranty, Bonds, and Financial Guaranty (RSA 401.1, VII)			
Other Casualty Risks. Insurance against any other casualty risk not otherwise specified under paragraph V. (RSA 401.1, VIII)			
Title (RSA 416-A)			
Fraternal (RSA 418:16)			

NEW JERSEY	Authorized to Transact	Currently Transacting	Applying for
(1) Fire (N.J.S.A. 17:17-1a)			
(2) Earthquake (N.J.S.A. 17:17-1a)			
(3) Growing Crops (N.J.S.A. 17:17-1a)			
(4) Ocean Marine (N.J.S.A. 17:17-1b)			
(5) Inland Marine (N.J.S.A. 17:17-1b)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NEW JERSEY (continued)	Authorized to Transact	Currently Transacting	Applying for
(6) Workers' Compensation and Employers Liability (N.J.S.A. 17:17-1e)			
(7) Automobile Liability (BI) (N.J.S.A. 17:17-1e)			
(8) Automobile Liability (PD) (N.J.S.A. 17:17-1e)			
(9) Automobile Physical Damage (N.J.S.A. 17:17-1e)			
(10) Aircraft Physical Damage (N.J.S.A. 17:17-1b)			
(11) Other Liability (N.J.S.A. 17:17-1e)			
(12) Boiler & Machinery (N.J.S.A. 17:17-1f)			
(13) Fidelity & Surety (N.J.S.A. 17:17-1g)			
(14) Credit (N.J.S.A. 17:17-1i)			
(15) Burglary & Theft (N.J.S.A. 17:17-1j)			
(16) Glass (N.J.S.A. 17:17-1k)			
(17) Sprinkler Leakage (N.J.S.A. 17:17-1l)			
(18) Livestock (N.J.S.A. 17:17-1m)			
(19) Smoke & Smudge (N.J.S.A. 17:17-1n)			
(20) Physical Loss to Buildings (N.J.S.A. 17:17-1o)			
(21) Radioactive Contamination (N.J.S.A. 17:17-1o)			
(22) Mechanical Breakdown/Power Failure (N.J.S.A. 17:17-1o)			
(23) Other (must be pre-approved by the Commissioner) (N.J.S.A. 17:17-1o)			
(26) Accident and Health (Property/Casualty Companies) (N.J.S.A. 17B:17-4)			
(27) Municipal Bond (N.J.A.C. 11:7)			
(28) Life (N.J.S.A. 17B:17-3)			
(29) Accident and Health (Life/Health Companies) (N.J.S.A. 17B:17-4)			
(30) Annuities (N.J.S.A. 17B:17-5)			
(31) Variable Contracts (N.J.S.A. 17B:28-1 et seq.)			
(33) Title (N.J.S.A. 17:46B-7)			
(34) Fraternal Benefit Society (N.J.S.A. 17:44B)			
(35) Residential Mortgage Guaranty (N.J.S.A. 46A-3)			
(36) Commercial Mortgage Guaranty (N.J.S.A. 46A-3)			

NEW MEXICO	Authorized to Transact	Currently Transacting	Applying for
Life and Annuities (NMSA Section 59A-7-2)			
Accident and Health (NMSA Section 59A-7-3)			
Property (NMSA Section 59A-7-4)			
Casualty (NMSA Section 59A-7-6)			
Variable Life and Annuity (NMSA Section 59A-7-7)			

NEW YORK	Authorized to Transact	Currently Transacting	Applying for
(Notes 1 and 2)			
(Section 1113(a) of the N.Y. Ins. Law)			
(1) Life			
(2) Annuities			
(3) (i) – A&H – Other than Non-Cancellable Disability			
(3) (ii) – A&H – Non-Cancellable Disability			
(4) Fire			
(5) Miscellaneous Property			
(6) Water Damage			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NEW YORK (continued)	Authorized to Transact	Currently Transacting	Applying for
(7) Burglary & Theft			
(8) Glass			
(9) Boiler and Machinery			
(10) Elevator			
(11) Animal			
(12) Collision			
(13) Personal Injury Liability			
(14) Property Damage Liability			
(15) Workers' Compensation and Employers' Liability			
(16) Fidelity and Surety			
(17) Credit			
(19) Motor Vehicle and Aircraft Physical Damage			
(20) Marine and Inland Marine			
(21) Marine Protection and Indemnity			
(22) Residual Value			
(24) Credit Unemployment			
(26) Gap			
(27) Prize Indemnification			
(28) Service Contract Reimbursement			
(29) Legal Services			
(30) Involuntary Unemployment			
(31) Salary Protection			
Monoline only:			
Title – Section 1113(a)(18) & Article 64 of the N.Y. Ins. Law			
Mortgage Guaranty - Section 1113(a)(23) & Article 65 of the N.Y. Ins. Law			
Financial Guaranty - Section 1113(a)(25) & Article 69 of the N.Y. Ins. Law			

Note 1: A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

Note 2: The company must have transacted business for a minimum of three (3) years prior to seeking admission. If the company was recently acquired, at least three (3) years of operating experience under the new management is required. An affiliated insurer admitted in New York and operating under the same ownership/management team for at least three (3) years may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.

NORTH CAROLINA	Authorized to Transact	Currently Transacting	Applying for
Life (NCGS 58-7-15)			
Life, Including Industrial and Credit Life			
Annuities			
Variable Annuities			
Variable Life			
Accident and Health - Cancelable			
Accident and Health - Non-Cancelable			
Accident and Health – Credit			
Fire (NCGS 58-7-15)			
Fire			
Miscellaneous Property - Extended Coverage			
Miscellaneous Property - Growing Crops			
Water Damage – Commercial			
Water Damage - Residence			
Burglary and Theft			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

NORTH CAROLINA (continued)	Authorized to Transact	Currently Transacting	Applying for
Glass			
Animal			
Collision – Automobile			
Collision – Other			
Motor Vehicle and Aircraft - Property Damage			
Motor Vehicle and Aircraft - Fire			
Motor Vehicle and Aircraft - Theft			
Motor Vehicle and Aircraft - Comprehensive			
Motor Vehicle and Aircraft - Collision			
Marine – Inland			
Marine – Ocean			
Marine Protection and Indemnity			
Other			
Casualty (NCGS 58-7-15)			
Accident and Health – Cancelable			
Accident and Health – Non Cancelable			
Accident and Health – Credit			
Water Damage – Commercial			
Water Damage – Residence			
Burglary and Theft			
Glass			
Boiler and Machinery			
Elevator			
Animal			
Collision – Automobile			
Collision – Other			
Personal Injury Liability – Automobile			
Personal Injury Liability – Other			
Property Damage Liability – Automobile			
Property Damage Liability - Other			
Workers' Compensation and Employer's Liability			
Fidelity and Surety			
Credit			
Title			
Motor Vehicle and Aircraft – Property Damage			
Motor Vehicle and Aircraft – Fire			
Motor Vehicle and Aircraft – Theft			
Motor Vehicle and Aircraft – Comprehensive			
Motor Vehicle and Aircraft – Collision			
Marine Protection and Indemnity			
Aircraft Voluntary Settlement			
Hole-in-One			
Other			
Mortgage Guaranty			

NORTH DAKOTA	Authorized to Transact	Currently Transacting	Applying for
Life & Annuity			
Accident & Health			
Property			
Casualty			
Variable Life and Annuity			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

OHIO	Authorized to Transact	Currently Transacting	Applying for
Life Companies (O.R.C. 3911.01)			
Life			
Accident and Health (Including Disability)			
Annuities			
Variable Authority (if licensed under O.R.C. 3911.01 for both Life and Annuities lines of business, such company may apply for Variable Annuity) (O.R.C. 3911.011)			
Property & Casualty (O.R.C. 3929.01(A))			
(1) Fire			
(2) Allied Lines			
(3) Farmowners Multiple Peril			
(4) Homeowners Multiple Peril			
(5) Commercial Multiple Peril			
(6) Ocean Marine			
(7) Inland Marine			
(8) Financial Guarantee			
(9) Medical Malpractice			
(10) Earthquake			
(11) Group A&H			
(12) Credit A&H (Group and Individual)			
(13a) Collectively Renewable A&H			
(13b) Noncancellable A&H			
(13c) Guaranteed Renewable A&H			
(13d) Nonrenewable for Stated Reasons Only			
(13e) Other Accident Only			
(13f) All Other A&H			
(14) Workers' Compensation (to the extent permitted by law)			
(15) Other Liability			
(16a) Private Passenger Auto No-Fault (personal injury protection to the extent permitted by law)			
(16b) Other Private Passenger Auto Liability			
(16c) Commercial Auto No-Fault (personal injury protection to the extent permitted by law)			
(16d) Other Commercial Auto Liability			
(17a) Private Passenger Auto Physical Damage			
(17b) Commercial Auto Physical Damage			
(18) Aircraft (all perils)			
(19) Fidelity			
(20) Surety			
(21) Glass			
(22) Burglary and Theft			
(23) Boiler and Machinery			
(24) Credit			
(25) Reinsurance Only			
(26) Other (list)			
Title Insurance (O.R.C. 3953)			

OKLAHOMA	Authorized to Transact	Currently Transacting	Applying for
Life (O.S. 36 §702)			
Surety (including bail) (OAC 365:25-5-41)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

OKLAHOMA (continued)	Authorized to Transact	Currently Transacting	Applying for
Surety (excluding bail) (O.S 36 §708)			
Title (O.S. 36 §709)			
Marine (O.S. 36 §705)			
Accident & Health (O.S. 36 §703)			
Property (O.S. 36 §704)			
Vehicle (O.S. 36 §706)			
Casualty (vehicle only) (O.S. 36 §706)			
Casualty (including vehicle)(O.S. 36 §707)			
Workers' Compensation (O.S. 36 §608, §612.2)			
Variable Annuity (O.S. 36 §6061, §6062, OAC 365:10.9.10)			
Variable Life (O.S. 36 §6061, §6062)			
Reinsurance (O.S. 36 §2132)			
Health Maintenance Organizations (O.S.36 §6901)			

OREGON	Authorized to Transact	Currently Transacting	Applying for
Life (ORS 731.170)			
Credit Life and Credit Health (ORS 743.371)			
Industrial Life Insurance (ORS 731.166)			
Health (ORS 731.162)			
Health Care Service Contractor (ORS 750.005)			
Health Care Service Contractor (Complementary Health Services) (ORS 750.005)			
Property (ORS 731.182)			
Casualty, Excluding Workers' Comp (ORS 731.158)			
Casualty, Including Workers' Comp (ORS 731.158)			
Marine & Transportation (ORS 731.174)			
Surety (ORS 731.186)			
Home Protection (only) (ORS 731.164)			
Mortgage (only) (ORS 731.178)			
Title (only) (ORS 731.190)			

PENNSYLVANIA	Authorized to Transact	Currently Transacting	Applying for
(Notes 1 and 2)			
Life			
Life and Annuities (40 P.S. § 382(a)(1))			
Separate Account – Variable Life (40 P.S. § 382 (a)(1))			
Separate Account – Variable Annuities (40 P.S. § 382 (a)(1))			
Accident and Health (40 P.S. § 382(a)(2))			
Property			
Fire and Allied Lines (40 P.S. § 382(b)(1))			
Inland Marine & Auto Physical (40 P.S. § 382(b)(2))			
Ocean Marine (40 P.S. § 382(b)(3))			
Casualty			
Fidelity and Surety (40 P.S. § 382(c)(1))			
Accident and Health (40 P.S. § 382(c)(2))			
Glass (40 P.S. § 382 (c)(3))			
Other Liability (40 P.S. § 382 (c)(4))			
Steam Boiler & Machinery (40 P.S. § 382 (c)(5))			
Burglary-Theft (40 P.S. § 382 (c)(6))			
Credit (40 P.S. § 382 (c)(7))			
Water (40 P.S. § 382 (c)(8))			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

PENNSYLVANIA (continued)	Authorized to Transact	Currently Transacting	Applying for
Elevator (40 P.S. § 382 (c)(9))			
Livestock (40 P.S. § 382 (c)(10))			
Auto Liability (40 P.S. § 382 (c)(11))			
Mine & Machinery (40 P.S. § 382 (c)(12))			
Personal Property Floater (40 P.S. § 382 (c)(13))			
Workers' Compensation (40 P.S. § 382 (c)(14)) (Note 3)			
Other (40 P.S. § 382 (e))			
Title (40 P.S. § 910-1)			

Note 1: A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

Note 2: The company must have transacted business for a minimum of one (1) year prior to seeking admission. If the company was recently acquired, at least one (1) year of operating experience under the new management is required. An affiliated insurer admitted in Pennsylvania and operating under the same ownership/management team for at least one year may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.

Note 3: The Department of Labor and Industry requires all insurers that are applying to write workers' compensation to complete and file an Initial Report of Accident and Illness Prevention Services. The Insurance Department will not issue a Certificate of Authority to an insurer to write workers' compensation insurance until the Department of Labor and Industry has indicated the company has made the necessary filing as required by the Workers' Compensation Act. The necessary form with instructions can be obtained at: http://www.insurance.pa.gov/Companies/DoingBusiness/Documents/LIBC_211I.pdf.

PUERTO RICO	Authorized to Transact	Currently Transacting	Applying for
Agricultural (Section 4.060 of the Insurance Code)			
Casualty (Section 4.080 of the Insurance Code)			
Disability (Section 4.030 of the Insurance Code)			
Fraternal Life (Chapter 36 of the Insurance Code)			
Health (Chapter 19 of the Insurance Code)			
Life (Section 4.020 of the Insurance Code)			
Marine & Transportation (Section 4.050 of the Insurance Code)			
Mortgage Loans (Chapter 23 of the Insurance Code)			
Title (Section 4.100 of the Insurance Code)			
Surety (Section 4.090 of the Insurance Code)			
Property (Section 4.040 of the Insurance Code)			
Variable Life (Section 4.020 of the Insurance Code)			
Variable Annuities (Section 4.020 of the Insurance Code)			
Vehicle (Section 4.070 of the Insurance Code)			

RHODE ISLAND	Authorized to Transact	Currently Transacting	Applying for
Life and Health Companies:			
Life (Note 1)			
Accident and Health (Note 1)			
Annuities (Note 1)			
Variable Life (Note 1)			
Variable Annuity (Note 1)			
Variable Contracts (Notes 1 and 2)			
Property and Casualty Companies: (Note 3)			
Fire			
Allied Lines			
Multi-Peril Crop			
Federal Flood			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

RHODE ISLAND (continued)	Authorized to Transact	Currently Transacting	Applying for
Farmowners Multi-Peril			
Homeowners Multi-Peril			
Commercial Multi-Peril			
Ocean Marine			
Inland Marine			
Medical Malpractice/Medical Liability			
Earthquake			
Accident & Health			
Workers' Compensation			
Other Liability			
Products Liability			
Automobile (Full Coverage)			
Aircraft (All Perils)			
Fidelity			
Surety			
Glass			
Burglary and Theft			
Boiler and Machinery			
Credit			
Warranty			
Title			
Financial Guaranty or Mortgage Guaranty			

A company will be granted authority for a line of business in Rhode Island only on the condition that the company already has authority to sell that line in its state of domicile.

Note 1: Includes individual and group, and credit and non-credit.

Note 2: Variable Contracts includes Variable Life and Variable Annuity.

Note 3: Or alternatively: All lines except Life, Annuities, Title, Mortgage Guaranty and Financial Guaranty.

SOUTH CAROLINA	Authorized to Transact	Currently Transacting	Applying for
Life and Annuities (SC 38-5-30)			
Accident and Health (SC 38-5-30)			
Property (SC 38-5-30)			
Casualty (SC 38-5-30)			
Surety (SC 38-5-30)			
Marine (SC 38-5-30)			
Title (SC 38-5-30)			

SOUTH DAKOTA	Authorized to Transact	Currently Transacting	Applying for
(1) Life			
(2) Health			
(3) Fire & Allied Lines			
(4) Inland & Ocean Marine			
(5) Workers' Compensation			
(6) Bodily Injury (No Auto)			
(7) Property Damage (No Auto)			
(8) Bodily Injury (Auto)			
(9) Property Damage (Auto)			
(10) Physical Damage (Auto)			
(11) Fidelity & Surety Bonds			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

SOUTH DAKOTA (continued)	Authorized to Transact	Currently Transacting	Applying for
(12) Glass			
(13) Burglary & Theft			
(14) Boiler & Machinery			
(15) Aircraft			
(16) Credit (includes Credit Life; Credit Health; Credit Mortgage Guaranty and GAP (Guaranteed Auto Protection))			
(17) Crop - Hail			
(18) Livestock			
(19) Title			
(20) Variable Annuity			
(21) Variable Life			
(22) Reinsurance			
(23-A) Travel			
(23-C) Bail Bonds			
(24) SD Farm Mutual (County)			
(25) SD Farm Mutual (State)			
(27) Personal			

TENNESSEE	Authorized to Transact	Currently Transacting	Applying for
Life (TCA 56-2-201), (a)			
Accident and Health (TCA 56-2-201), (a)			
Credit (TCA 56-2-201), (a)			
Variable Contracts (TCA 56-2-201), (a)			
Property (TCA 56-2-201), (a), (b)			
Vehicle (TCA 56-2-201), (a), (c)			
Casualty (TCA 56-2-201) (a), (d)			
Surety (TCA 56-2-201) (a), (e)			
Title (TCA 56-35-112) (a)			

- (a) Company may only write lines in Tennessee that they are authorized to write in their domiciliary state.
- (b) Includes Fire and Extended Coverage, Other Allied Lines, Homeowners Multiple Peril, Commercial Multiple Peril, Earthquake, Growing Crops, Water Damage – Sprinkler Leakage, Ocean Marine and Inland Marine.
- (c) Automobile Bodily Injury, Automobile Property Damage and Automobile Physical Damage. (The Vehicle class is to be used when the company requests Vehicle only and no other Casualty line)
- (d) All lines listed under (c) above in addition to Disability, General Liability, Workers' Compensation, Burglary and Theft, Personal Property Floater, Glass, Boiler, Water Damage, Credit, Elevator, Livestock, Collision, Malpractice, Miscellaneous.
- (e) Credit, Accident and Health, Fidelity, Performance Contracts and Bonds, Indemnification Insurance and Mortgage Guaranty.

TEXAS	Authorized to Transact	Currently Transacting	Applying for
Fire			
Allied Coverages (a)			
Hail, growing crops only			
Rain			
Inland Marine (b)			
Ocean Marine			
Aircraft Liability			
Aircraft Physical Damage			
Accident			
Health			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

TEXAS (continued)	Authorized to Transact	Currently Transacting	Applying for
Workers' Comp & Emp. Liability			
Employer's Liability			
Automobile Liability (c)			
Automobile Physical Damage (d)			
Liability other than Automobile (e)			
Fidelity and Surety			
Glass			
Burglary and Theft			
Forgery			
Boiler and Machinery			
Credit (f)			
Livestock (g)			
Title (h)			
Mortgage Guaranty Type I (i)			
Mortgage Guaranty Type II (i)			
Life (includes Annuity)			
Variable Life			
Variable Annuity			

When one of the above coverages includes more than one kind or sub-line of insurance, the selection of that coverage authorizes the company to write one or more of the specified kinds of insurance included in that coverage.

- (a) Includes, but not limited to, Extended Coverage, Windstorm, Lightning, Hurricane, Hail (except growing crops), Explosion, Riot, Civil Commotion, Smoke, Aircraft, Land Vehicles, Physical Loss Form, Additional Extended Coverage, Vandalism, Malicious Misc
- (b) Includes Personal Property Floater.
- (c) Includes Bodily Injury, Medical Payments, Property Damage, and other Automobile Liability.
- (d) Includes Fire, Theft, Collision, Comprehensive and other Automobile Physical Damage.
- (e) Includes Bodily Injury, Medical Payments and Property Damage with regards to Comprehensive Personal Liability, Owners, Landlords and Tenants, Manufacturers and Contractors, Product, Contractual, Elevator (including Elevator Collision), Employers' Liability, Professional Liability for Physicians, Podiatrists, Certified Anesthetists, and Hospitals, and other Liability other than Automobile.
- (f) Includes Credit Involuntary Unemployment; excludes Mortgage Guaranty.
- (g) Mortality.
- (h) May be written only by Title insurance companies except those companies transacting title insurance prior to October 1, 1967. Includes Attorney's Title insurance companies as authorized by Texas Insurance Code, Chapter 2551.
- (i) May be written only by Mortgage Guaranty insurance companies as authorized by Texas Insurance Code, Chapter 3502.

UTAH	Authorized to Transact	Currently Transacting	Applying for
Health Maintenance Organization (Utah Code Ann. §31A-8-101(5))			
Limited Health Plan (Utah Code Ann. §31A-8-101(3)(a))			
Limited Health Plan – Dental			
Limited Health Plan – Vision			
Nonprofit Health Plan (Utah Code Ann. §31A-7-102)			
Life Insurance (Utah Code Ann. §31A-1-301(110))			
Annuity (Utah Code Ann. §31A-1-301(9))			
Variable Contract (Utah Code Ann. §31A-20-106)			
Accident & Health (Utah Code Ann. §31A-1-301(1)(a))			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

UTAH (continued)	Authorized to Transact	Currently Transacting	Applying for
Bail Bond Surety (Utah Code Ann. § 31A-1-301(12))			
Credit Guarantee (Utah Code Ann. § 31A-1-301(37)(a))			
Legal Expense (Utah Code Ann. § 31A-1-301(107)(a))			
Liability Insurance (Utah Code Ann. § 31A-1-301(108)(a))			
Marine & Transportation (Utah Code Ann. § 31A-1-301(90) & 31A-1-301 (130))			
Motor Club (Utah Code Ann. § 31A-1-301(125))			
Professional Liability, excluding medical malpractice (Utah Code Ann. § 31A-1-301(108))			
Professional Liability, including medical malpractice (Utah Code Ann. § 31A-1-301(119) & 31A-1-301(151))			
Property Insurance (Utah Code Ann. § 31A-1-301(152)(a)(b))			
Surety Insurance (Utah Code Ann. § 31A-1-301(176))			
Title Insurance (Utah Code Ann. § 31A-1-301(179))			
Vehicle Liability Insurance (Utah Code Ann. § 31A-1-301(184))			
Workers' Compensation Insurance (Utah Code Ann. § 31A-1-301(187))			

VERMONT	Authorized to Transact	Currently Transacting	Applying for
Life (Section 3301(a)(1))			
Variable Annuity (Section 3301(a)(1)) and (Section 3857)			
Variable Life (Section 3301(a)(1)) and (Section 3857)			
Health (Section 3301(a)(2))			
Casualty (Section 3301(a)(3))			
Marine and Transportation (Section 3301(a)(4))			
Marine Protection and Indemnity (Section 3301(a)(5))			
Wet Marine and Transportation (Section 3301(a)(6))			
Property (Section 3301(a)(7))			
Surety (Section 3301(a)(8))			
Title (Section 3301(a)(9))			
Multiple Line (Section 3301(a)(10))			

VIRGINIA	Authorized to Transact	Currently Transacting	Applying for
(§ 38.2 101 through 134)			
Life and Health and Fraternal Benefit Society			
01 Life			
02 Industrial Life			
03 Credit Life			
04 Variable Life			
05 Annuities			
06 Variable Annuities			
07 Accident and Sickness			
08 Credit Accident and Sickness			
99 Managed Care Health Insurance Plan *			
Title			
33 Title			
Property and Casualty			
07 Accident and Sickness			
08 Credit Accident and Sickness			
09 Fire			
10 Miscellaneous Property and Casualty			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

VIRGINIA (continued)	Authorized to Transact	Currently Transacting	Applying for
11 Farmowners Multi Peril			
12 Homeowners Multi Peril			
13 Commercial Multi Peril			
14 Ocean Marine			
15 Inland Marine			
16 Workers' Comp-Emp Liability			
17 Liability Other Than Auto			
18 Auto Liability			
19 Auto Physical Damage			
20 Aircraft Liability			
21 Aircraft Physical Damage			
23 Fidelity			
24 Surety			
25 Glass			
26 Burglary and Theft			
27 Boiler and Machinery			
28 Credit			
29 Animal			
30 Water Damage			
32 Legal Services			
55 Home Protection			
56 Mortgage Guaranty			
74 Credit Involuntary Unemployment			
75 Credit Property			
99 Managed Care Health Insurance Plan *			

- * Companies applying to operate a Managed Care Health Insurance Plan (MCHIP) will be required to obtain a Certificate of Quality Assurance (Certificate) from the Virginia Department of Health pursuant to § 38.2-5800 et seq. of the Code of Virginia. Upon receipt of an application to operate an MCHIP, the Bureau of Insurance will send a letter to the applicant describing the requirements for operating an MCHIP that includes the requirement to obtain a Certificate of Quality Assurance from the Virginia Department of Health.

WASHINGTON	Authorized to Transact	Currently Transacting	Applying for
Life (RCW 48.11.020)			
Disability (RCW 48.11.030)			
Health (RCW 48.11.030)			
Health Maintenance Organization (RCW 48.46)			
Health Care Service Contractor (RCW 48.44)			
Limited Health Care Service Contractor (RCW 48.44)			
Property (RCW 48.11.040)			
Marine and Transportation (RCW 48.11.050)			
Vehicle (RCW 48.11.060)			
General Casualty (RCW 48.11.070)			
Surety (RCW 48.11.080)			
Title (RCW 48.11.100)			
Ocean Marine (RCW 48.11.105)			

WEST VIRGINIA	Authorized to Transact	Currently Transacting	Applying for
Life (WV Code §33-1-10(a))			
Accident & Sickness (WV Code §33-1-10(b))			
Fire (WV Code §33-1-10(c))			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

WEST VIRGINIA (continued)	Authorized to Transact	Currently Transacting	Applying for
Marine (WV Code §33-1-10(d))			
Casualty without Workers' Compensation (WV Code §33-1-10(e))			
Casualty with Workers' Compensation (WV Code §33-1-10(e)(14))			
Surety (WV Code §33-1-10(f)(1)) Fidelity			
Surety (WV Code §33-1-10(f)(2)) Performance			
Surety (WV Code §33-1-10(f)(3)) Financial Guaranty			
Surety (WV Code §33-1-10(f)(3)) Mortgage Guaranty (monoline)			
Surety (WV Code §33-1-10(f)(4)) Title			
Reinsurance (WV Code §33-1-11)*			
Variable Annuity (WV Code §33-13A)			
Variable Life (WV Code §33-13A)			
Physicians' Mutual (WV Code §33-20F)			
Reciprocal (WV Code §33-21) **			
Farmers Mutual Fire (WV Code §33-22)			
Fraternal (WV Code §33-23)			
Hospital Service Corporation (WV Code §33-24)			
Medical Service Corporation (WV §33-24)			
Health Service Corporation (WV §33-24)			
Dental Service Corporation (WV §33-24)			

* Indicate above the kinds of insurance to be reinsured, if application is for authority to transact reinsurance only.

** Indicate above the kinds of insurance to be written by the reciprocal insurer

WISCONSIN	Authorized to Transact	Currently Transacting	Applying for
(s. Ins 6.75, Wis. Adm. Code)			
(1) (a) Life and Insurance Annuities - Nonparticipating			
(1) (a) Life and Insurance Annuities -Participating			
(1) (b) Variable Life and Variable Annuities			
(1) (c) Disability (includes health)			
(2) (a) Fire, Inland Marine and Other Property			
(2) (b) Ocean Marine			
(2) (c) Disability (includes health)			
(2) (d) Liability and Incidental Medical Expense			
(2) (e) Automobile			
(2) (f) Fidelity Insurance			
(2) (g) Surety Insurance			
(2) (h) Title			
(2) (i) Mortgage Guaranty			
(2) (j) Credit Insurance			
(2) (k) Workers' Compensation Insurance			
(2) (l) Legal Expense Insurance			
(2) (m) Credit Unemployment Insurance			
(2) (n) Miscellaneous			
(2) (o) Aircraft			

WYOMING	Authorized to Transact	Currently Transacting	Applying for
Life, including annuities (WS 26-5-102)			
Variable Contracts (WS 26-5-102)			

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

WYOMING (continued)	Authorized to Transact	Currently Transacting	Applying for
Disability (WS 26-5-103)			
Property (WS 26-5-104)			
Surety (WS 26-5-105)			
Casualty (WS 26-5-106)			
Marine and Transportation (WS 26-5-107)			
Multiple Lines (WS 26-5-108)			
Title (WS 26-5-109)			

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: <See UCAA FAQs for details> **UCAA Type:** <See UCAA FAQs for details> **Other:** <See UCAA FAQs for details>

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

Address: <Enter Applicant Company Address> City: <Enter Applicant Company City>

State/Province: <Enter Applicant Company State/Province> Postal Code: <Enter App. Co. Zip/Postal Code> Phone: <Enter App. Co. Phone>

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

2. a. Are you a citizen of the United States?

Yes ☐ No ☐

b. Are you a citizen of any other country?

Yes ☐ No ☐

If yes, what country? _____

3. Affiant's occupation or profession: _____

4. Affiant's business address: _____

Business telephone: _____ Business Email: _____

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended</u> <u>(MM/YY)</u>	<u>Degree</u> <u>Obtained</u>
<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended</u> <u>(MM/YY)</u>
			<u>Degree</u> <u>Obtained</u>
<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>

7. Present or proposed position with the Applicant Company: _____

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐ ☐ No ☐ ☐

If any claims were made on the bond, give details: _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐ ☐ No ☐ ☐

If yes, give details: _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes ☐ ☐ No ☐ ☐

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☐

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☐

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☐

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☐

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☐

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☐

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☐

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☐

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☐

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.:

FEIN:

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☐

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details:

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☐

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☐

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☐ No ☐

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: <See UCAA FAQs for details> **UCAA Type:** <See UCAA FAQs for details> **Other:** <See UCAA FAQs for details>

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
Address: <Enter Applicant Company Address> City: <Enter Applicant Company City>
State/Province: <Enter Applicant Company State/Province> Postal Code: <Enter App. Co. Phone: <Enter App. Co.

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☐

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

4. Government Identification Number if not a U.S. Citizen:

<u>Government ID Number:</u>	<u>Country of Issuance:</u>
_____	_____
_____	_____
_____	_____

5. Foreign Student ID# (if applicable) : _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

6. Date of Birth: (MM/DD/YY) : _____ Place of Birth, City: _____
State/Province: _____ Country: _____

7. Name of Affiant's Spouse (if applicable) : _____

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact

[company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ [name of CRA, address] ("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature) _____ (Date)

State of: _____ County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

FLORIDA CERTIFICATE OF ASSUMING INSURER

I, _____,
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in Florida, hereby certify that

(name of assuming insurer) (“Assuming Insurer”):

1. Submits to the jurisdiction of any court of competent jurisdiction in Florida for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer’s rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.
2. Designates the Chief Financial Officer of the State of Florida as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.
3. Submits to the authority of the Florida Office of Insurance Regulation (“Office”) to examine its books and records and agrees to bear the expense of any such examination.
4. Submits with this form a current list of insurers domiciled in Florida reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Office at least once per calendar quarter.

Dated: _____

(name of assuming insurer)

BY: _____
(name of officer)

(title of officer)



Florida Office of Insurance Regulation

APPLICATION FOR TRUSTEED REINSURER STATUS

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in English and in searchable PDF format, unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

APPLICATION FOR TRUSTEED REINSURER STATUS

INSTRUCTIONS

SECTION I – APPLICATION

Section I-1 Checklist and Application Certification

Applicants for Trusteed Reinsurer Status in Florida must submit the Checklist (pages 6-8) and Application Certification (page 12) included in this form, in addition to all other documentation and forms required herein. Applicant should list the lines of business (and respective code numbers) the company intends to reinsure in the state of Florida on the Application Certification.

Section I-2 Applicant Groups

Applicants that are groups including incorporated and individual unincorporated underwriters are subject to the requirements of Section 624.610(3)(c)3.b., Florida Statutes.

APPLICATION FOR TRUSTEED REINSURER STATUS

SECTION II - LEGAL

Section II-1 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

Section II-2 Service of Process Consent & Agreement

Provide an executed Form OIR-C1-1524, "Uniform Consent to Service of Process."

Section II-3 Trust Agreement

Provide a copy of the trust agreement and all amendments certified by the insurance regulator of the state of domicile of the trust or the insurance regulatory of another state who, pursuant to the terms of the trust agreement, has accepted principal regulatory oversight of the trust.

Section II-4 Trust Agreement Checklist

Complete the checklist in regard to the trust agreement (pages 9-11). Any NO answer on the checklist indicates that the trust agreement does not meet the requirements of the Florida Statutes or Florida Administrative Code.

APPLICATION FOR TRUSTEED REINSURER STATUS

SECTION III - FINANCIAL

Section III-1 Financial Statements

Submit a copy of the latest financial statements consisting of the most recent Annual Statement of the trust prepared using the form approved by the National Association of Insurance Commissioners (“NAIC”) for financial reporting which is signed and notarized as required by such form and including all supporting documents required to be included or filed in accordance with the NAIC Annual Statement Instructions.

Section III-2 Trustee Statement

Submit a statement from the trustee of the trust certifying the total amount of assets in the trust; a listing of all assets in the trust in sufficient detail to determine if these assets are of a quality substantially similar to that required in Part II of Chapter 625, Florida Statutes; and certification that the trust will not expire prior to the following December 31st.

Note that the amount in the trust must meet the requirements of Section 624.610(3)(c)3.a. Florida Statutes, which requires an amount not less than the assuming insurer’s liabilities attributable to reinsurance ceded by U.S. domiciled insurers, and in addition, a trusteed surplus of not less than \$20,000,000, USD. Such statement shall be the most recent available but in no event prior to December 31st of the preceding year.

Section III-3 Letter from Insurance Regulator with Regulatory Oversight

Provide a letter from the insurance regulator of the state of domicile or of the insurance regulator that has accepted principal regulatory oversight of the trust stating that the trust is authorized and showing the kinds of reinsurance or lines of business that the reinsurer is authorized to transact.

Section III-4 Certificate of Assuming Insurer to Submit to Examination

Submit form OIR-C1-1469, “Certificate of Assuming Insurer to Submit to Examination and Bear the Cost of Examination.” To aid the Office in determining if an examination of the trust or reinsurer is needed, please include a copy of the latest independent audit report, quarterly statement, and state examination report, or a statement that these do not exist.

APPLICATION FOR TRUSTEED REINSURER STATUS

SECTION IV - MANAGEMENT

Section IV-1 Management Information

Submit Form OIR-C1-2221, "Management Information Form," fully describing the management, ownership, and control, direct or indirect, of the insurer up to and including any 10 percent or greater interest holders of the ultimate parent. A Management Information Form should be submitted for each entity in the ownership chain.

Forms should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

Section IV-2 Biographical Affidavits as to Officers, Directors, and Shareholders

Provide a copy of Form OIR-C1-1423, the "National Association of Insurance Commissioners Biographical Affidavit" (NAIC Form 11) for each individual listed in Section IV-1. Applicant may omit individuals listed for those entities in the organizational structure between the immediate parent and the ultimate parent. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

All questions must be answered. All "Yes" answers must be explained.

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

APPLICATION FOR TRUSTEED REINSURER STATUS

CHECKLIST

Applicant Name: _____

Home Office Address: _____
(Street Address) (City)

(State/Province) (Country) (Zip Code or Equivalent)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

SECTION I - APPLICATION

- ☐ 1. Checklist (pages 6-8)
- ☐ 2. Application Certification (page 12)

SECTION II – LEGAL DOCUMENTS

- ☐ 1. Authorization letter, if applicable
- ☐ 2. Uniform Consent to Service of Process (Form OIR-C1-1524)
- ☐ 3. Trust agreement
 - ☐ a. Includes all amendments
 - ☐ b. Certified by the insurance regulator having oversight of the Trust
- ☐ 4. Trust Agreement Checklist (pages 9-11)

APPLICATION FOR TRUSTEED REINSURER STATUS

CHECKLIST

Applicant Name: _____

SECTION III – FINANCIAL

- ☐ 1. Financial Statements
 - ☐ a. Most recent Annual Statement for the trust on NAIC forms
 - ☐ i. Signed
 - ☐ ii. Notarized
 - ☐ iii. Includes all supporting documents as per NAIC instructions
- ☐ 2. Trustee statement
 - ☐ a. Certifies the total amount of assets in the trust in compliance with Section 624.610(3)(c)3.a., Florida Statutes
 - ☐ b. Listing of all trust assets as per the instructions in Section III-2
 - ☐ c. Certifies that the trust will not expire before the following December 31st
 - ☐ d. Statement is the most recent, and not prior to December 31st of preceding year
- ☐ 3. Letter from insurance regulator with regulatory oversight
 - ☐ a. Indicates that the trust is authorized
 - ☐ b. Shows kind of reinsurance or lines of business trust is authorized to transact
- ☐ 4. Certificate of Assuming Insurer to Submit to Examination (OIR-C1-1469)
 - ☐ a. Latest independent audit report; and
 - ☐ b. Quarterly statement; and
 - ☐ c. State examination report; or
 - ☐ d. Statement that the documents in items a.-c. do not exist

APPLICATION FOR TRUSTEED REINSURER STATUS

CHECKLIST

Applicant Name: _____

SECTION IV – MANAGEMENT

- ☐ 1. Management Information Forms (Form OIR-C1-2221) submitted for all required entities
- ☐ 2. Biographical Affidavits (Form OIR-C1-1423) submitted for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. "Yes" answers explained
 - ☐ c. Signed
 - ☐ d. Notarized

APPLICATION FOR TRUSTEED REINSURER STATUS

TRUST AGREEMENT FOR TRUSTEED REINSURER

Reinsurer Name: _____

Grantor of the Trust: _____

Trust Dated: _____

1. Is the trustee, as evidenced in the trust agreement, a bank or trust company that is subject to supervision by any state of the U.S. or that is a member of the Federal Reserve System?

Yes: _____ No: _____

2. Does the trust agreement create a trust account into which the assets shall be deposited to provide security for ceding insurers in order that credit may be allowed for the reinsurance ceded?

Yes: _____ No: _____ Section where located _____

3. Does the trust agreement provide for the following:

- a) The trust agreement provides for the payment of valid claims for business written in the U.S.

Yes: _____ No: _____ Section where located _____

- b) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the U.S.

Yes: _____ No: _____ Section where located _____

- c) Legal title to the assets of the trust shall be vested in the trustee (bank or trust company) for the benefit of the grantor's (reinsurer) U.S. ceding insurers, their assigns, and successors in interest.

Yes: _____ No: _____ Section where located _____

- d) The trust shall be subject to examination by the Office.

Yes: _____ No: _____ Section where located _____

- e) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

Yes: _____ No: _____ Section where located _____

APPLICATION FOR TRUSTEED REINSURER STATUS

- f) No later than February 28 of each year, the trustee of the trust shall report to the Office of Insurance Regulation in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

Yes: ____ No: ____ Section where located _____

- g) Trustee shall notify in writing the domiciliary and non-domiciliary insurance regulators within 10 days of receipt of a claim that would reduce the trust to an amount below the minimum.

Yes: ____ No: ____ Section where located _____

- h) If the trust is inadequate because it contains an amount less than the amount required by the Office of Insurance Regulation or, if the grantor (reinsurer) of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee (bank or trust company) shall comply with an order of the insurance regulator with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee (bank or trust company) to transfer to the insurance regulator with regulatory oversight over the trust, or other designated receiver all of the assets of the trust.

Yes: ____ No: ____ Section where located _____

- i) The assets shall be distributed by, and claims shall be filed with and valued by the insurance regulator with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

Yes: ____ No: ____ Section where located _____

- j) If the insurance regulator with regulatory oversight over the trust determines that the assets of the trust account or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the insurance regulator with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee (bank or trust company) for distribution in accordance with the trust agreement.

Yes: ____ No: ____ Section where located _____

- k) The grantor agrees to waive any rights otherwise available to it under United States law that is inconsistent with the provisions outlined in (h), (i), and (j) above.

Yes: ____ No: ____ Section where located _____

APPLICATION FOR TRUSTEED REINSURER STATUS

- l) Are the trust assets required to be comprised and maintained with cash or securities of a quality substantially similar to those which will qualify as admitted assets under Part II of Chapter 625 Florida Statutes?

Yes: _____ No: _____ Section where located _____

- m) Trust agreement contains a condition that any amendments to the trust approved by the insurance regulator having jurisdiction shall be reported in a manner that the Florida Office of Insurance Regulation will receive notice of any amendment no later than 30-days after such approval. The Florida Office of Insurance Regulation does not have to be specifically named, but the trust provision must inclusive enough that such notice is assured.

Yes: _____ No: _____ Section where located _____

Name of Person preparing this form _____

Title _____

Date _____

APPLICATION FOR TRUSTEED REINSURER STATUS

APPLICATION CERTIFICATION

The below certification must be executed by two officers of applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary.

The undersigned state that they are officers having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to seek status as an Trusteed Reinsurer in Florida, that they have read said application, and that they know the contents thereof and verify that the items indicated in the application checklist are true and complete to the best of their knowledge and have been submitted with the application. The undersigned represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant on behalf of which they have acted executed the instrument.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes.

By: _____ **Lines of Business** **Code Number**

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers will be accepted only if the applicant does not have these positions.

OIR-C1-1466
Rev.: 9/21
690-144.002

APPLICATION FOR TRUSTEED REINSURER STATUS

FLORIDA OFFICE OF INSURANCE REGULATION LINES OF BUSINESS BY COMPANY CODES

R010	Reinsurance - Fire
R020	Reinsurance - Allied Lines
R030	Reinsurance - Farmowners Multi-Peril
R040	Reinsurance - Homeowners Multi-Peril
R050	Reinsurance - Commercial Multi-Peril
R080	Reinsurance - Ocean Marine
R090	Reinsurance - Inland Marine
R100	Reinsurance - Financial Guaranty
R106	Reinsurance - Auto Warranties
R110	Reinsurance - Medical Malpractice
R120	Reinsurance - Earthquake
R160	Reinsurance - Workers' Compensation
R170	Reinsurance - Other Liability
R173	Reinsurance - Prepaid Legal
R192	Reinsurance - Private Passenger Auto Liability
R194	Reinsurance - Commercial Auto Liability
R211	Reinsurance - Private Passenger Auto Physical Damage
R212	Reinsurance - Commercial Auto Physical Damage
R220	Reinsurance - Aircraft
R230	Reinsurance – Fidelity
R240	Reinsurance - Surety
R245	Reinsurance - Bail Bonds
R250	Reinsurance - Glass
R260	Reinsurance - Burglary and Theft
R270	Reinsurance - Boiler and Machinery
R280	Reinsurance - Credit
R285	Reinsurance - Title
R290	Reinsurance - Livestock
R300	Reinsurance - Industrial Fire
R310	Reinsurance - Mortgage Guaranty
R400	Reinsurance - Ordinary Life and Annuity
R405	Reinsurance - Individual/Group Variable Annuities
R410	Reinsurance - Group Life and Annuity
R420	Reinsurance - Variable Life
**R425	Reinsurance - Fraternal Life
**R430	Reinsurance - Fraternal Health
R440	Reinsurance - Credit Life
R441	Reinsurance - Credit Disability
R450	Reinsurance - Accident and Health
R520	Reinsurance - Industrial Extended Coverage
R540	Reinsurance - Mobile Home Multi Peril
R550	Reinsurance - Mobile Home Physical Damage
R570	Reinsurance - Crop Hail
R607	Reinsurance - Home Warranties
R608	Reinsurance - Service Warranties
R610	Reinsurance - Other Warranty
R620	Reinsurance – Miscellaneous Casualty

**A Fraternal Benefit Society can cede business but can only reinsure another society as part of a merger or consolidation.
[632.614, Florida Statutes]

OIR-C1-1466

Rev.: 9/21

69O-144.002



Florida Office of Insurance Regulation

**CERTIFICATE OF ASSUMING REINSURER TO SUBMIT TO EXAMINATION
AND BEAR THE COST OF EXAMINATION**

I, _____, _____
(name of officer) (title of officer)

hereby certify that _____
(name of assuming reinsurer)

submits to the authority of the Florida Office of Insurance Regulation to examine its
books, records, and trust accounts and agrees to bear the expense of any such
examination. _____
(name of assuming reinsurer)

grants the Florida Office of Insurance Regulation permission to examine and copy on
the premises of the trust custodian all books, records, and assets of the reinsurer in
possession of the trust custodian and grants the trust custodian permission to make
the custodian's records available to the Florida Office of Insurance Regulation for
examination during the custodian's regular business hours.

By: _____

Print Name: _____

Title: _____

Date: _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Uniform Consent to Service of Process

_____ Original Designation

_____ Amended Designation

(must be submitted directly to states)

Applicant Company Name: _____

Previous Name (if applicable): _____

Statutory Home Office Address: _____

City, State, Zip: _____ NAIC CoCode: _____

The Applicant Company named above, organized under the laws of _____, and regulated under the laws of _____ for purposes of complying with the laws of the State(s) designate hereunder relating to the holding of a certificate of authority or the conduct of an insurance business within said State(s), pursuant to a resolution adopted by its board of directors or other governing body, hereby irrevocably appoints the officers of the State(s) and their successors identified in Exhibit A, or where applicable appoints the required agent so designated in Exhibit A hereunder as its attorney in such State(s) upon whom may be served any notice, process or pleading as required by law as reflected on Exhibit A in any action or proceeding against it in the State(s) so designated; and does hereby consent that any lawful action or proceeding against it may be commenced in any court of competent jurisdiction and proper venue within the State(s) so designated; and agrees that any lawful process against it which is served under this appointment shall be of the same legal force and validity as if served on the entity directly. This appointment shall be binding upon any successor to the above named entity that acquires the entity's assets or assumes its liabilities by merger, consolidation or otherwise; and shall be binding as long as there is a contract in force or liability of the entity outstanding in the State. The entity hereby waives all claims of error by reason of such service. The entity named above agrees to submit an amended designation form upon a change in any of the information provided on this power of attorney.

Applicant Company Officers' Certification and Attestation

One of the two Officers (listed below) of the Applicant Company must read the following very carefully and sign:

1. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant Company.
2. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at _____.

Date

Signature of President

Full Legal Name of President

Date

Signature of Secretary

Full Legal Name of Secretary

Uniform Certificate of Authority (UCAA)
Uniform Consent to Service of Process
Exhibit A

Place an "X" before the names of all the States for which the person executing this form is appointing the designated agent in that State for receipt of service of process:

☐ AL	Commissioner of Insurance # and Resident Agent*	☐ MO	Director of Insurance #
☐ AK	Director of Insurance #	☐ MT	Resident Agent*
☐ AZ	Director of Insurance # ^	☐ NE	Officer of Company* or Resident Agent* (circle one)
☐ AR	Resident Agent *	☐ NH	Commissioner of Insurance #
☐ AS	Commissioner of Insurance #	☐ NV	Commissioner of Insurance Commission # ^
☐ CO	Commissioner of Insurance # or Resident Agent*	☐ NJ	Commissioner of Banking and Insurance #^
☐ CT	Commissioner of Insurance #	☐ NM	Superintendent of Insurance #
☐ DE	Commissioner of Insurance #	☐ NY	Superintendent of Financial Services #
☐ DC	Commissioner of Insurance and Securities Regulation # or Local Agent* (circle one)	☐ NC	Commissioner of Insurance
☐ FL	Chief Financial Officer # ^	☐ ND	Commissioner of Insurance # ^
☐ GA	Commissioner of Insurance and Safety Fire # and Resident Agent*	☐ OH	Resident Agent*
☐ GU	Commissioner of Insurance #	☐ OR	Resident Agent*
☐ HI	Insurance Commissioner # and Resident Agent*	☐ OK	Commissioner of Insurance #
☐ ID	Director of Insurance # ^	☐ PR	Commissioner of Insurance #
☐ IL	Director of Insurance #	☐ RI	Superintendent of Insurance ^
☐ IN	Resident Agent* ^	☐ SC	Director of Insurance #
☐ IA	Commissioner of Insurance #	☐ SD	Director of Insurance # ^
☐ KS	Commissioner of Insurance ^	☐ TN	Commissioner of Insurance #
☐ KY	Secretary of State #	☐ TX	Resident Agent*
☐ LA	Secretary of State #	☐ UT	Resident Agent* ^
☐ MD	Insurance Commissioner #	☐ VT	Resident Agent*
☐ ME	Resident Agent* ^	☐ VI	Lieutenant Governor/Commissioner#
☐ MI	Resident Agent *	☐ WA	Insurance Commissioner #
☐ MN	Commissioner of Commerce ~	☐ WV	Secretary of State # @
☐ MS	Commissioner of Insurance and Resident Agent* BOTH are required.	☐ WY	Commissioner of Insurance #

For the forwarding of Service of Process received by a State Officer complete Exhibit B listing by state the entities (one per state) with **full name and address where service of process is to be forwarded**. Use additional pages as necessary. Colorado will forward Service of Process to the Secretary of the Applicant Company and requires a resident agent for foreign entities. Exhibit not required for New Jersey, and North Carolina. Florida accepts only an individual as the entity and requires an email address. New Jersey allows but does not require a foreign insurer to designate a specific forwarding address on Exhibit B. SC will not forward to an individual by name; however, it will forward to a position, e.g., Attention: President (or Compliance Officer, etc.). Washington requires an email address on Exhibit B.

* Attach a completed Exhibit B listing the Resident Agent for the Applicant Company (one per state). Include state name, Resident Agent's **full name and street address**. Use additional pages as necessary. (DC* requires an agent within a ten-mile radius of the District), (MT requires an agent to reside or maintain a business in MT).

^ Initial pleadings only.

@ Form accepted only as part of a Uniform Certificate of Authority application.

MA will send the required form to the Applicant Company when the approval process reaches that point.

~ Minnesota does not forward Service of Process. To effectively serve the Commissioner of Commerce, use the process under Minn. Stat. § 45.028. Applicant Company may complete Exhibit B to provide a Service of Process address that Commerce may keep on file.

Exhibit A

Uniform Certificate of Authority (UCAA)
Uniform Consent to Service of Process
Exhibit B

Complete for each state indicated in Exhibit A:

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

State: _____ Name of Entity: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

Street Address: _____

Exhibit B

Resolution Authorizing Appointment of Attorney

BE IT RESOLVED by the Board of Directors or other governing body of

(Applicant Company Name)

this _____ day of _____, 20____, that the President or Secretary of said entity be and are hereby authorized by the Board of Directors and directed to sign and execute the Uniform Consent to Service of Process to give irrevocable consent that actions may be commenced against said entity in the proper court of any jurisdiction in the state(s) of

in which the action shall arise, or in which plaintiff may reside, by service of process in the state(s) indicated above and irrevocably appoints the officer(s) of the state(s) and their successors in such offices or appoints the agent(s) so designated in the Uniform Consent to Service of Process and stipulate and agree that such service of process shall be taken and held in all courts to be as valid and binding as if due service had been made upon said entity according to the laws of said state.

CERTIFICATION:

I, _____, Secretary of

(Applicant Company Name)

state that this is a true and accurate copy of the resolution adopted effective the ____ day of _____, 20____ by the Board of Directors or governing board at a meeting held on the _____ day of _____, 20____ or by written consent dated ____ day of _____, 20____.

Date _____

Secretary

CERTIFICATE OF CERTIFIED REINSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in Florida, in order to be considered for approval in this state, hereby certify that _____ (“Assuming Insurer”):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in Florida for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer’s rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Chief Financial Officer of the State of Florida as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer, in accordance with Section 48.151, Florida Statutes.

3. Agrees to provide security in an amount equal to 100 percent (100%) of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.

4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.

5. Agrees to annually file information comparable to relevant provisions of the National Association of Insurance Commissioners’ financial statement for use by insurance markets, in accordance with Rule 69O-144.007(8)(h), Florida Administrative Code.

6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.

7. Agrees to annually file audited financial statements, regulatory filings, and an actuarial opinion in accordance with Rule 69O-144.007(8)(h), F.A.C..

8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.

9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated: _____
(name of assuming insurer)

BY: _____
(name of officer)

(title of officer)

NAIC FORM CR-F

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FORM CR-F – PART 1

ASSUMED REINSURANCE – PROPERTY/CASUALTY BUSINESS **AS OF DECEMBER 31 (MOST RECENT YEAR-END)**

Form CR-F Part 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-F must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 1 provides information with respect to reinsurance assumed by the Certified Reinsurer (or applicant) from ceding insurers domiciled in the U.S. and abroad. Part 1 data may be reported on an aggregate basis as opposed to reporting data applicable to each individual ceding insurer. However, reporting entities are required to segregate and subtotal this aggregate information in accordance with the categories listed below, as applicable.*

***Note: Additional Instructions for Assuming Insurers Subject to Filing Schedule F Part 1 of the NAIC Annual Statement –**
In certain cases, a non-U.S. domiciled assuming insurer is required to file annually a Schedule F Part 1 from the NAIC Annual Statement. The Schedule F Part 1 filing is submitted to a U.S. state in which the assuming insurer maintains a trust fund in a qualified U.S. financial institution for the payment of the valid claims of its U.S. ceding insurers with respect to U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer. The purpose of the Schedule F Part 1 filing is to enable the commissioner of the state in which the trust is domiciled to determine the sufficiency of the trust fund, and its Form CR-F filing does not affect this Schedule F Part 1 filing requirement. The assuming insurer's Schedule F Part 1 should only include U.S. reinsurance it has assumed that is supported by this trust.

In such cases, the assuming insurer may exclude from Form CR-F Part 1 U.S. reinsurance assumed that is reported in its Schedule F Part 1. However, the assuming insurer must attach a copy of its Schedule F Part 1 filing with its Form CR-F, and must clearly indicate on Form CR-F Part 1 that its U.S. reinsurance assumed is reported in this manner (i.e., its Form CR-F Part 1 includes non-U.S. reinsurance assumed and U.S. reinsurance assumed under its Certified Reinsurer status, while its attached Schedule F Part 1 includes U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer).

<u>Group or Category</u>	<u>Line Number</u>
Reinsurance Assumed from Affiliated Ceding Insurers	
U.S. Affiliated	0199999
Non-U.S. Affiliated	0299999
Total Affiliated	0399999
Reinsurance Assumed from Unaffiliated Ceding Insurers	
U.S. Unaffiliated.....	0499999
Non-U.S. Unaffiliated	0599999
Total Unaffiliated	0699999
Total Reinsurance Assumed	0799999

Column Descriptions

Column 5	–	Assumed Reinsurance Premium
Column 6	–	Reinsurance on Paid Losses and Loss Adjustment Expenses (LAE) Report losses and loss adjustment expenses due and payable to ceding insurers.
Column 7	–	Reinsurance on Known Case Losses and LAE Report known case reserves for losses and LAE assumed from ceding insurers.

- Column 8 – Totals of Columns 6 + 7 for each category.
- Column 9 – Contingent Commissions Payable
Report profit commissions generated from assumed reinsurance contracts due to ceding insurers. Report commissions net of return profit commissions. Negative commissions are possible, (i.e., when a contingent commission is receivable.)
- Column 10 – Assumed Premiums Receivable
Report receivable amounts net of commissions payable
- Column 12 – Funds Held By or Deposited with Reinsured Companies
- Column 13 – Letters of Credit Posted
- Column 14 – Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit
- Column 15 – Amount of Assets Pledged or Collateral Held in Trust
This column reflects amounts that are not otherwise reflected in Column 12 of this schedule that are under the control of ceding insurance companies.

FORM CR-F – PART 2

CEDED REINSURANCE – PROPERTY/CASUALTY BUSINESS
AS OF DECEMBER 31 (MOST RECENT YEAR-END)

Form CR-F Part 2 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-F must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 2 provides information with respect to reinsurance ceded or retroceded by a Certified Reinsurer (or applicant) to assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Only Columns 1, 3, 4, 6 and 15 (in total) are required to be completed with respect to the assuming insurer-specific data applicable to the top ten assuming insurers (or additional assuming insurers to meet 75% minimum). Part 2 data applicable to all other assuming insurers may be reported on an aggregate basis; however, each of the columns from 6 through 19 must be completed for the aggregated data. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable.

<u>Group or Category</u>	<u>Line Number</u>
Reinsurance Ceded/Retroceded to Affiliated Assuming Insurers	
U.S. Affiliated	0199999
Non-U.S. Affiliated	0299999
Total Affiliated	0399999
Reinsurance Ceded/Retroceded to Unaffiliated Assuming Insurers	
U.S. Unaffiliated.....	0499999
Non-U.S. Unaffiliated	0599999
Total Unaffiliated	0699999
Total Reinsurance Ceded.....	0799999

Column Descriptions

- Column 1 – Company Code or ID Number
- The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.
- Column 3 – Name of Reinsurer
- Column 4 – Domiciliary Jurisdiction
- Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is attached to these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:
- www.nationsonline.org/oneworld/countrycodes.htm**
- If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

- Column 5 – Reinsurance Contracts Ceding 75% or More Direct Premiums Written
- For the data reported by individual assuming insurer, a separate entry should be made to identify each individual contract (except those listed under “Exceptions” below) which provides for the cession of 75% or more of direct or assumed premiums written by the reporting entity under such cession during the year. Such line item entries should be identified by inserting a 2 in this column. The reinsurance transactions so identified shall include both treaty and facultative cessions of direct or assumed business written by the reporting entity.
- Exceptions:
- Intercompany reinsurance transactions with affiliates.
 - Reinsurance transactions involving any group, association, pool, or organization of insurers that engage in joint underwriting activities and which are subject to examination by any state regulatory authority or which operate pursuant to any state or federal statutory or administrative authorization.
 - Any reinsurance transaction in which the annual gross premium ceded is less than 5% of policyholder surplus.
 - Reinsurance transactions involving captive insurance companies.
- Column 6 – Reinsurance Premiums Ceded
- Column 7 – Reinsurance Recoverable on Paid Losses
- Column 8 – Reinsurance Recoverable on Paid LAE
- Column 9 – Reinsurance Recoverable on Known Case Loss Reserves
- Column 10 – Reinsurance Recoverable on Known Case LAE Reserves
- Column 11 – Reinsurance Recoverable on IBNR Loss Reserves
- Column 13 – Reinsurance Recoverable on Unearned Premiums
- Column 14 – Contingent Commissions
- Include: Contingent commissions receivable from a reinsurer. Regular commissions should be netted with ceded balances payable in Column 16.
- If Column 14 is less than zero, report the amount in Column 17.
- Column 15 – Total Columns 7 through 14
- Column 16 – Ceded Balances Payable
- Column 17 – Other Amounts Due to Reinsurers
- Both Column 16 and Column 17 are liabilities owed to the reinsurer.
- Deduct: Reinsurance premiums paid by a ceding company prior to the effective date of the contract.
- Exclude: Funds held by company under reinsurance treaties, which are included in Column 19.
- Items entered in Column 17 may represent miscellaneous balances owed by the reinsured to the reinsurer on ceded transactions.

Column 18 – Net Amount Recoverable from Reinsurers
Column 19 – Funds Held By Company Under Reinsurance Treaties

Form CR-F PART 1

Assumed Reinsurance as of December 31, Current Year (000 Omitted)

[illegible]

Ceded Reinsurance as of December 31, Current Year (000 Omitted)

[illegible]

NAIC FORM CR-S

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FORM CR-S – PART 1 – SECTION 1

REINSURANCE ASSUMED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURED COMPANY AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 1, Section 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 1, Section 1 provides information on all reinsurance assumed for life insurance, annuities, deposit fund and other liabilities without life or disability contingencies, and related benefits from ceding insurers domiciled in the U.S. and abroad. Part 1, Section 1 data may be reported on an aggregate basis as opposed to reporting data applicable to each individual ceding insurer. However, reporting entities are required to segregate and subtotal this aggregate information in accordance with the categories listed below, as applicable.*

*Note: Additional Instructions for Assuming Insurers Subject to Filing Schedule S Part 1 of the NAIC Annual Statement –
In certain cases, a non-U.S. domiciled assuming insurer is required to file annually a Schedule S Part 1 from the NAIC Annual Statement. The Schedule S Part 1 filing is submitted to a U.S. state in which the assuming insurer maintains a trust fund in a qualified U.S. financial institution for the payment of the valid claims of its U.S. ceding insurers with respect to U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer. The purpose of the Schedule S Part 1 filing is to enable the commissioner of the state in which the trust is domiciled to determine the sufficiency of the trust fund, and its Form CR-S filing does not affect this Schedule S Part 1 filing requirement. The assuming insurer's Schedule S Part 1 should only include U.S. reinsurance it has assumed that is supported by this trust.

In such cases, the assuming insurer may exclude from Form CR-S Part 1 U.S. reinsurance assumed that is reported in its Schedule S Part 1. However, the assuming insurer must attach a copy of its Schedule S Part 1 filing with its Form CR-S, and must clearly indicate on Form CR-S Part 1 that its U.S. reinsurance assumed is reported in this manner (i.e., its Form CR-S Part 1 includes non-U.S. reinsurance assumed and U.S. reinsurance assumed under its Certified Reinsurer status, while its attached Schedule S Part 1 includes U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer).

<u>Group or Category</u>	<u>Line Number</u>
General Account	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total General Account	0799999
Separate Accounts	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999

Total Separate Accounts.....	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999, 1199999).....	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999, 1299999).....	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

- Column 7 – Amount in Force at End of Year
 For catastrophe-reinsurance (CAT), disability reinsurance (DIS), accidental death benefit reinsurance (ADB) and annuity reinsurance (ACO and AMCO), leave this column blank.
- Column 9 – Premiums
 For deposit funds and other liabilities without life or disability contingencies, leave this column blank.
- Column 10 – Reinsurance Payable on Paid and Unpaid Losses
 For deposit funds and other liabilities without life or disability contingencies, leave this column blank.
- Column 11 – Modified Coinsurance Reserve
 Report the amount of reserves held by the ceding company under modified coinsurance contracts.
 Include separate accounts modified coinsurance reserves.
- Column 12 – Funds Withheld Under Coinsurance
 Report the amount of funds withheld by the ceding company on coinsurance contracts.

FORM CR-S – PART 1 – SECTION 2

REINSURANCE ASSUMED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURED COMPANY AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 1, Section 2 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 1, Section 2 provides information on all reinsurance assumed for accident and health insurance from ceding insurers domiciled in the U.S. and abroad. Amounts are to be reported in U.S. dollars with thousands omitted. Part 1, Section 2 data may be reported on an aggregate basis as opposed to reporting data applicable to each individual ceding insurer. However, reporting entities are required to segregate and subtotal this aggregate information in accordance with the categories listed below, as applicable.*

***Note: Additional Instructions for Assuming Insurers Subject to Filing Schedule S Part 1 of the NAIC Annual Statement –**
In certain cases, a non-U.S. domiciled assuming insurer is required to file annually a Schedule S Part 1 from the NAIC Annual Statement. The Schedule S Part 1 filing is submitted to a U.S. state in which the assuming insurer maintains a trust fund in a qualified U.S. financial institution for the payment of the valid claims of its U.S. ceding insurers with respect to U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer. The purpose of the Schedule S Part 1 filing is to enable the commissioner of the state in which the trust is domiciled to determine the sufficiency of the trust fund, and its Form CR-S filing does not affect this Schedule S Part 1 filing requirement. The assuming insurer's Schedule S Part 1 should only include U.S. reinsurance it has assumed that is supported by this trust.

In such cases, the assuming insurer may exclude from Form CR-S Part 1 U.S. reinsurance assumed that is reported in its Schedule S Part 1. However, the assuming insurer must attach a copy of its Schedule S Part 1 filing with its Form CR-S, and must clearly indicate on Form CR-S Part 1 that its U.S. reinsurance assumed is reported in this manner (i.e., its Form CR-S Part 1 includes non-U.S. reinsurance assumed and U.S. reinsurance assumed under its Certified Reinsurer status, while its attached Schedule S Part 1 includes U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer).

<u>Group or Category</u>	<u>Line Number</u>
Reinsurance Assumed from Affiliated Ceding Insurers	
U.S. Affiliated	0199999
Non-U.S. Affiliated	0299999
Total Affiliated	0399999
Reinsurance Assumed from Unaffiliated Ceding Insurers	
U.S. Unaffiliated.....	0499999
Non-U.S. Unaffiliated	0599999
Total Unaffiliated	0699999
Total Reinsurance Assumed	0799999

Column Descriptions

Column 7	–	Assumed Reinsurance Premiums
Column 8	–	Unearned Assumed Reinsurance Premiums
Column 9	–	Reserve Liability Other Than For Unearned Premiums
Column 10	–	Reinsurance Payable on Paid and Unpaid Losses

Column 11 – Modified Coinsurance Reserve

Report the amount of the reserves held by the ceding company under modified coinsurance contracts.

Column 12 – Funds Withheld Under Coinsurance

Report the amount of funds withheld by the ceding company on coinsurance contracts.

FORM CR-S – PART 2

REINSURANCE RECOVERABLE ON PAID AND UNPAID LOSSES **AS OF DECEMBER 31, (MOST RECENT YEAR-END)**

Form CR-S Part 2 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 2 provides information with respect to reinsurance recoverable on paid and unpaid losses from assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable.

<u>Group or Category</u>	<u>Line Number</u>
Life and Annuity	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total Life and Annuity	0799999
Accident and Health	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999
Total Accident and Health.....	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999 and 1199999)	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999 and 1299999)	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

- Column 3 – Effective Date
Report earliest effective date of contracts with recoverables reported applicable to individual assuming insurers.
- Column 4 – Name of Company (Reinsurer)
- Column 5 – Location (Domiciliary Jurisdiction)
Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is attached to these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:
www.nationsonline.org/oneworld/countrycodes.htm
If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.
- Column 6 – Paid Losses
Report reinsured claim amounts paid by the reporting entity but not yet reimbursed by the reinsurer.
- Column 7 – Unpaid Losses
Include the reinsured amounts for claims that are in course of settlement and will become recoverable from reinsurers following payment.

FORM CR-S – PART 3 – SECTION 1

REINSURANCE CEDED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES
WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS
AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 3 Section 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 3 Section 1 provides information with respect to reinsurance ceded or retroceded by a Certified Reinsurer (or applicant) to assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Part 3 Section 1 data applicable to all other assuming insurers may be reported on an aggregate basis. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

<u>Group or Category</u>	<u>Line Number</u>
General Account	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total General Account	0799999
Separate Accounts	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999
Total Separate Accounts.....	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999, 1199999)	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999, 1299999)	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the

entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

Column 3 – Effective Date

Report earliest effective date of contracts with recoverables reported applicable to individual assuming insurers.

Column 4 – Name of Company (Reinsurer)

Column 5 – Location (Domiciliary Jurisdiction)

Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is available in the appendix of these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:

www.nationsonline.org/oneworld/countrycodes.htm

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Type of Reinsurance Ceded

Use the following abbreviations to identify the plan and type of reinsurance. For example, group coinsurance with funds withheld should be identified as COFW/G. (If there is more than one type of reinsurance in the same reinsurance company, show each type on a separate line.) NOTE: The type should be entered in all capital letters, and ALL reinsurance types must be followed by /G (for Group) or /I (for Individual).

Abbreviations:

I	Individual
G	Group

{ All Reinsurance Types should be followed by /I or /G.

REINSURANCE TYPES

CO	Coinsurance	ACO	Annuity coinsurance
COFW	Coinsurance with funds withheld	ACOFW	Annuity coinsurance with funds withheld
MCO	Modified coinsurance	AMCO	Annuity modified coinsurance
MCOFW	Modified coinsurance with funds withheld	AMCOFW	Annuity modified coinsurance with funds withheld
COMB	Combination coinsurance/modified coinsurance	ACOMB	Annuity combination coinsurance/modified coinsurance
COMBW	Combination coinsurance/modified coinsurance with funds withheld	ACOMBW	Annuity combination coinsurance/modified coinsurance with funds withheld
YRT	Yearly renewable term	GMDB	Guaranteed minimum death benefit
CAT	Catastrophe	GMDBFW	Guaranteed minimum death benefit funds withheld
OTH	Other reinsurance	ADB	Accidental death benefit
		DIS	Disability benefits

NOTE: The insurance type should be entered in all capital letters.

Column 7 – Amount in Force at End of Year

Report the ceded amount of the basic life insurance policy only

For catastrophe-reinsurance (CAT), disability reinsurance (DIS), accidental death benefit reinsurance (ADB) and annuity reinsurance (ACO and AMCO), leave this column blank.

Column 8 – Reserve Credit Taken Current Year

Column 9 – Reserve Credit Taken Prior Year

Column 10 – Premiums

Amounts included in this column should represent reinsurance ceded premiums on an incurred basis.

For deposit funds and other liabilities without life or disability contingencies, leave this column blank.

Columns
11 & 12 – Outstanding Surplus Relief

Outstanding surplus relief means the amount of surplus not yet reported as income.

Report the amount of initial commissions and expense allowance not yet recovered by the reinsurer for the following types of treaties (individual or group): CO, ACO, MCO, AMCO, COFW, ACOFW, MCOFW, AMCOFW, COMB, ACOMB, ACOMBW AND COMBW. This column does not apply to CAT, DIS, ADB, YRT or other non-proportional reinsurance treaties.

Include the outstanding surplus resulting from reinsurance of separate accounts business.

Column 13 – Modified Coinsurance Reserve

Report the amount of reserves held under modified coinsurance contracts. Include separate accounts modified coinsurance reserves.

Column 14 – Funds Withheld Under Coinsurance

Report the amount of funds withheld on coinsurance contracts.

FORM CR-S – PART 3 – SECTION 2

REINSURANCE CEDED ACCIDENT AND HEALTH INSURANCE
AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 3 Section 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 3 Section 1 provides information with respect to reinsurance ceded or retroceded by a Certified Reinsurer (or applicant) to assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Part 3 Section 1 data applicable to all other assuming insurers may be reported on an aggregate basis. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

<u>Group or Category</u>	<u>Line Number</u>
General Account	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total General Account	0799999
Separate Accounts	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999
Total Separate Accounts	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999, 1199999)	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999, 1299999)	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

Column 3 – Effective Date

Report earliest effective date of contracts with recoverables reported applicable to individual assuming insurers.

Column 4 – Name of Company (Reinsurer)

Column 5 – Location (Domiciliary Jurisdiction)

Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is available in the appendix of these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:

www.nationsonline.org/oneworld/countrycodes.htm

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Type

Use the following abbreviations to identify the plan and type of reinsurance. For example, group coinsurance with funds withheld should be identified as COFW/G. (If there is more than one type of reinsurance in the same reinsurance company, show each type on a separate line.) NOTE: The type should be entered in all capital letters, and ALL reinsurance types must be followed by /G (for Group) or /I (for Individual).

Abbreviations:

I	Individual
G	Group

{ All Reinsurance Types should be followed by /I or /G.

REINSURANCE TYPES

CO	Coinsurance	COFW	Coinsurance with funds withheld
MCO	Modified coinsurance	MCOFW	Modified coinsurance with funds withheld
COMB	Combination coinsurance/modified coinsurance	COMBW	Combination coinsurance/modified coinsurance with funds withheld
YRT	Yearly renewable term	CAT	Catastrophe
LTC	Long-Term Care	OTH	Other reinsurance

NOTE: The insurance type should be entered in all capital letters.

Column 7 – Premiums

Amounts included in this column should represent reinsurance ceded premiums on an incurred basis.

Column 8 – Unearned Premiums (Estimated)

Amounts represent, by company, the ceded part of the unearned premium.

- Column 9 – Reserve Credit Taken Other Than For Unearned Premiums
- Columns 10 and 11 – Outstanding Surplus Relief
- Outstanding surplus relief means the amount of surplus not yet reported as income.
- Report the amount of initial commissions and expense allowance not yet recovered by the reinsurer for the following types of treaties (individual or group): CO, MCO, COFW, MCOFW, COMB or COMBW. This column does not apply to YRT or other nonproportional reinsurance treaties.
- Column 12 – Modified Coinsurance Reserve
- Report the amount of reserves held under modified coinsurance contracts.
- Column 13 – Funds Withheld Under Coinsurance
- Report the amount of funds withheld on coinsurance contracts.

Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

**NAIC Form CR-S
DIR-C1-2118 (Rev.09/21)
Rule 69O-144.002**

Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

NAIC Form CR-S
OIR-C1-2118 (Rev.09/21)
Rule 69O-144.002

Form CR-S – PART 2

Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

[illegible]

Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

NAIC Form CR-S
OIR-C1-2118 (Rev.09/21)
Rule 69O-144.002

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

NAIC Form CR-S
OIR-C1-2118 (Rev.09/21)
Rule 69O-144.002



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Florida

By

Name of Registrant

On Behalf of Following Insurance Companies

Name

Address

_____	_____
_____	_____
_____	_____
_____	_____

Date: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name;
- (b) Home office address;
- (c) Principal executive office address;

- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;
- (e) The principal business of the person;
- (f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and
- (g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

- (a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
- (b) Purchases, sales or exchanges of assets;
- (c) Transactions not in the ordinary course of business;
- (d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;
- (e) All management agreements, service contracts, and all cost-sharing arrangements;
- (f) Reinsurance agreements;
- (g) Dividends and other distributions to shareholders;
- (h) Consolidated tax allocation agreements; and
- (i) Any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 4 of the Act.

Sales, purchases, exchanges, loans, or extensions of credit, investments, or guarantees involving one-half of 1% or less of the registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the registrant.

ITEM 6. EMPLOYMENT CONTRACTS

Furnish the following information with regards to each employment contract entered into by the insurer and each of its affiliates with any of the other officers and/or directors of the insurer: name of employees, position held, annual remuneration, other perquisites, and term of contract.

ITEM 7. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

- (a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and
- (b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 8. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 9. FINANCIAL STATEMENTS AND EXHIBITS

- (a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.
- (b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

- (c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or regulation Sections 4 and 6.

ITEM 10. FORM C REQUIRED

Form C, Summary of Changes to Registration Statement (OIR-A1-2116), must be prepared and filed with this Form B.

ITEM 11. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

I have reviewed the above, and to the best of my knowledge, information, and belief it is correct.

By: _____

Print Name: _____

Title: _____

[Corporate Seal]

Date: _____

STATE OF _____

COUNTY OF _____

CERTIFICATION

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20____, by _____
(name of person)

as _____ for _____.
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known OR Produced Identification _____

Type of identification produced _____

My Commission Expires _____

69O-171.011 – Property Claims Litigation Data Call.

(1) Each authorized insurer or insurer group issuing personal lines or commercial lines residential property insurance policies shall report, for each such line of insurance, the information required by Section 624.424(11), F.S., or required by rule, on and pursuant to the instructions in Form OIR-B1-2222, “Florida Property Claims Litigation Data Call Reporting Form,” effective 02/22, hereby incorporated by reference and available at www.flrules.org/XXXXXX.

(2) For purposes of this rule, “personal lines or commercial lines residential property insurance” includes the following lines of business:

- (a) Allied Lines;
- (b) Commercial Multiple Peril;
- (c) Farmowners Multiple Peril;
- (d) Homeowners Multiple Peril;
- (e) Industrial Extended Coverage;
- (f) Industrial Fire;
- (g) Mobile Homeowners Multiple Peril;
- (h) Mobile Homeowners Physical Damage Only; and
- (i) Property (Fire).

(3) The first report will be due on March 1, 2023, for claims closed in Calendar Year 2022. Reports for the preceding calendar year are due on or before March 1 of each year and shall be filed electronically at <https://www.flair.com/iportal>.

Rulemaking Authority 624.308(1), 624.424(1)(c), (11) FS. Law Implemented 624.307(1), 624.424 FS. History—
New _____.

690-191.021 Scope.

The following rules developed by the Office of Insurance Regulation govern the issuance of a Certificate of Authority and operation of a health maintenance organization pursuant to the authority set forth in part I, chapter 641, F.S.

Rulemaking Authority 641.36 FS. Law Implemented 641.36 FS. History—New 2-22-88, Formerly 4-31.021, 4-191.021.

690-191.027 Application for Certificate of Authority.

Substantial rewording of Rule 690-191.027, F.A.C. follows. See Florida Administrative Code for present text.

(1) An application for a person applying for a certificate of authority as a health maintenance organization consists of the following:

(a) Form OIR-C1-942, “Application for Certificate of Authority Health Maintenance Organization,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(b) Form OIR-C1-1263, “Application for Certificate of Authority Health Maintenance Organization Rehabilitation Administrative Expense Fund (Pursuant to Section 641.227, F.S.),” effective 6/96, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(c) Form OIR-B2-1093, “Small Employer Carrier’s Application to Become a Risk Assuming Carrier or a Reinsuring Carrier, as Required by Section 627.6699(9), Florida Statutes,” effective 8/03, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(d) Form OIR-C1-905, “Instructions for Furnishing Background Investigative Reports,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(e) Form OIR-C1-938, “Fingerprint Payment and Submission Procedures,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(f) Form OIR-C1-1423, “Biographical Affidavit,” 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX; and

(g) Form OIR-C1-2221, “Management Information Form,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX.

(2) A person applying for a certificate of authority as a health maintenance organization shall submit forms in subsection (1) as directed by the Office electronically at <https://www.floir.com/iportal>.

An application, provided by the Applications Coordination Section, Insurer Services Support, Office of Insurance Regulation, Tallahassee, Florida 32399-0300, incorporated in rule 690-191.107, F.A.C., accompanied by a filing fee of One Thousand Dollars (\$1,000.00) payable to “State of Florida” shall be completed by each entity desiring to obtain a Certificate of Authority as an HMO. The applicant shall specify in the application the contact person or persons for the HMO for purposes of corresponding between the Office and the HMO concerning the application. During the investigation of the application, only contact persons specified by the HMO shall be permitted to access the application materials submitted. The applicant shall submit the original application with one (1) copy and address any correspondence to the Applications Coordination Section, Insurer Services Support, Office of Insurance Regulation, Tallahassee, Florida 32399-0300. The Office shall accept and shall begin its investigation of an application for a Certificate of Authority any time after an organization has filed with the Department of Health and Rehabilitative Services an application for a Health Care Provider Certificate pursuant to part IV, chapter 641, F.S. The Office shall not issue a Certificate of Authority to any applicant who does not possess a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services. All application reviews will be conducted pursuant to chapter 120, F.S.

Rulemaking Authority 641.36 FS. Law Implemented ~~120.60(2)~~, 641.21, 641.22, 641.29(1) FS. History—New 2-22-88, Amended 10-25-89, Formerly 4-31.027, Amended 5-28-92, Formerly 4-191.027.

690-191.028 Standards for Fingerprint Cards for New Applicants and Acquisition Applications.

(1) Fingerprints shall be submitted only on a card provided by the Office of Insurance Regulation. Others will not be accepted.

(2) The Office has adopted a form, referenced in rule 690-191.107, F.A.C., of these rules, which provides instructions on how fingerprint cards are to be completed.

~~(3) This requirement also applies to those individuals who qualify under paragraph 69O-191.030(3)(f), F.A.C., of these rules.~~

Rulemaking Authority 641.36 FS. Law Implemented 641.21(1)(d) FS. History—New 5-28-92, Formerly 4-191.028.

69O-191.075 Annual and Quarterly Reports.

Substantial rewording of Rule 69O-191.075, F.A.C. follows. See Florida Administrative Code for present text.

(1) Each HMO shall file with the Office a full and true statement of its financial condition, transactions, and affairs.

(a) An annual statement covering the preceding fiscal year shall be filed within 3 months after the end of the fiscal year, and quarterly statements within 45 days after the end of each of its quarterly reporting periods for the first three quarters of the fiscal year.

(b) The Office shall grant an extension of time for filing an annual or quarterly statement if there exist conditions beyond the control of the authorized HMO, such as rehabilitation pursuant to chapter 631, F.S., or the laws of the state of domicile; severe damage to the HMO's physical premises by a natural or man-made disaster; or some other reason of similar gravity and severity. The extension shall be for the amount of time reasonable to file under the conditions which justified the extension.

(c) For purposes of this rule, the requirement that statements be filed with the Office means that the statement has been transmitted electronically to the National Association of Insurance Commissioners and that the executed Jurat page of said statement has been transmitted electronically to the Office via the Regulatory Electronic Filing System, "REFS." The date affixed by the Office's electronic data processing system shall serve as evidence of the timeliness of the statement. Annual and quarterly statements in any other format shall not be submitted to the Office.

(2) Annual and Quarterly Statement Reporting.

Each HMO shall submit its annual and quarterly statement information electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions incorporated by reference in paragraph 69O-137.001(3)(b), F.A.C.

(3) Manuals Adopted.

(a) Annual statements shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(a), F.A.C.

(b) Quarterly statements shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(b), F.A.C.

(c) Copies of the manuals are available:

1. From the National Association of Insurance Commissioners at <http://www.naic.org>; and
2. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.

~~(1) Each HMO shall furnish to the Office an annual report at the time specified in section 641.26, F.S., on a form furnished by the Office of Insurance Regulation, Life and Health Financial Oversight, incorporated in rule 69O-191.107, F.A.C. The annual report shall be submitted to the Office electronically through <http://www.flor.com/portal>. The completed annual statement form shall be accompanied by the items required in section 641.26, F.S., as well as a supplemental actuarial certification and an organization chart of the HMO identifying ownership and affiliated companies, and shall be submitted by April 1 or within three months after the end of its reporting period. The audit report required by section 641.26, F.S., that is found to have assets which are not allowed pursuant to section 641.35, F.S., shall be granted a fifteen (15) day extension from the date of notification of disallowed assets to resubmit a corrected audit report. The extension will be granted only for submission of a corrected audit report. If the Office determines that the HMO has been notified previously that the asset has been disallowed, the audit report will be deemed not filed. No extension shall be granted for correction of the audit report.~~

~~(2) HMOs may elect to report to the Office based upon the fiscal year of the HMO. If the fiscal year elected is different than the calendar year, the HMO shall inform the Office in writing the use of any fiscal year which ends at~~

a time other than December 31. However, the election of a new reporting period shall not result in the submission of an annual report which would be submitted more than one year after the most recent previous annual report filed by the HMO.

(3) Any HMO which has operations in states other than Florida shall file its annual report based upon its total operations. In addition, the HMO shall file a separate schedule of all financial statements specified in the annual report form, including the audited financial statement, which covers the Florida operations only.

(4) If an HMO constitutes a portion of or a division of a certificated entity, the entity shall file its annual report based upon its total operations. In addition, the entity shall file a separate schedule of all financial statements specified in the annual report form, including the audited financial statement, which covers the HMO operations only.

(5) The annual report shall include adequate disclosure of material transactions between the HMO and a related party. The disclosure shall include:

(a) The nature of the relationship(s) involved.

(b) A description of the transactions, including transactions to which no amounts or nominal amounts were ascribed, for each of the periods for which income statements are presented, and such other information deemed necessary to an understanding of the effects of the transaction on the financial statements.

(c) The dollar amounts of transactions for each of the periods for which income statements are presented and the effects of any change in the method of establishing the terms from that used in the preceding period.

(d) Amounts due from or to related parties as of the date of each balance sheet presented and, if not otherwise apparent, the terms and manner of settlement.

(e) Any HMO which makes investments in a mutual or money market fund shall provide to the Office an annual report of the fund which shall include a complete listing of the underlying assets of that fund. The list of assets submitted shall be the most recent available. The assets which make up a majority of the types of assets of the fund shall determine which classification under sections 641.35(13) and (14), F.S., shall apply to the fund. The determination shall be made at least on an annual basis for each fund. New funds shall be reviewed with the first quarterly report filed by the HMO after the initial investment.

(6) Quarterly reports shall be submitted to the Office within forty five (45) days following the end of each operating quarter. The initial operating quarter commences after the issuance of a Certificate of Authority. Quarterly reports shall be submitted on a form, provided by the Office of Insurance Regulation, Life and Health Financial Oversight, incorporated by reference in subsection 690.137.001(3), F.A.C., and also be filed electronically in accordance with subsection (1), of this section, and shall contain the following supplemental schedules:

(a) A complete identification and dollar value breakdown of all short term investments with individual balances;

(b) A complete list of all debtors with account balances greater than 10% of gross premiums receivable;

(c) An aging analysis on all premium receivables;

(d) A complete aging, identification and dollar value breakdown of all prepaid expenses with individual balances greater than 10% of total prepaid expenses;

(e) A complete identification and dollar value breakdown of all restricted assets and restricted funds with individual balances greater than 10% of the respective account balance total;

(f) A complete identification and dollar value breakdown of all long term investments with individual balances;

(g) A complete identification and dollar value breakdown of all intangible assets and goodwill with individual balances greater than 10% of total intangible assets;

(h) A complete identification and dollar value breakdown of other assets with individual balances greater than 10% of total other assets;

(i) Any liabilities reported that are considered subordinated or result from a surplus note shall be identified by a complete identification and dollar value breakdown and shall be accompanied by a copy of the surplus note agreement identifying the subordination of the liability.

Each HMO is required to submit four (4) quarterly reports in addition to an annual report each fiscal year.

(7) Any request for an extension of filing the annual report shall be in writing and the reason(s) for the extension explained in detail. All requests must be filed with the Office fifteen (15) days prior to the deadline date for filing the annual report. Any extension request received less than fifteen (15) days prior to due date will be denied except for unavoidable circumstances. Unavoidable circumstances include, but are not limited to, death of key personnel or destruction of records by fire, hurricane, or other natural disasters.

Rulemaking Authority 641.26, 641.36 FS. Law Implemented 624.424, 641.26(1) FS. History—New 2-22-88, Amended 10-25-89, Formerly 4-31.075, Amended 5-28-92, Formerly 4-191.075, Amended 7-30-17.

690-191.085 Fees.

Checks for the original application filing or amendments thereto, for filing of each annual report, and for any other fees collected under this law, shall be made payable to the "Florida Department of Financial Services." "State Treasurer, State of Florida."

Rulemaking Authority 641.36 FS. Law Implemented 641.29 FS. History—New 2-22-88, Formerly 4-31.085, 4-191.085.

690-191.097 Change of Ownership.

Change of ownership shall comply with section 628.4615, F.S., and the transaction shall be approved by the Office of Insurance Regulation pursuant to section 628.4615, F.S. Acquisition applications are available from the Office of Insurance Regulation's website: <http://www.florir.com/portal>, and is incorporated herein by reference.

Rulemaking Authority 641.36 FS. Law Implemented 628.4615 FS. History—New 2-22-88, Amended 10-25-89, Formerly 4-31.097, Amended 5-28-92, Formerly 4-191.097.

690-191.107 Prescribed Forms.

(1) The forms listed below are incorporated into, and made a part of, these rules by reference.

FORM NUMBER	DESCRIPTION	DATE OF LATEST REVISION
(a) OIR-C1-942 http://www.flrules.org/Gateway/reference.asp?No=Ref-08307	Application For Certificate of Authority Health Maintenance Organization	12/05
(b) OIR-A2-949	Annual Report Supplement—Contracts Issued & Outstanding	07/04
(c) OIR-A2-950	Annual Report Supplement—Damage Claims & Medical Injury	07/04
(d) OIR-C1-448	Acquisition Application	12/05
(e) OIR-C1-938 http://www.flrules.org/Gateway/reference.asp?No=Ref-08296	Fingerprint Payment and Submission Procedure	5/13
(f) OIR-C1-903	Fingerprint Invoice	12/05
(g) OIR-C1-144	Service of Process Consent and Agreement	06/04
(h) OIR-C1-1423	Biographical Affidavit	8/14
(i) OIR-C1-450	Authority for Release of Information	5/00
(j) OIR-D0-516	Insurance Holding Company System Annual Registration Statement	5/16
(k) OIR-A2-1083 http://www.flrules.org/Gateway/reference.asp?No=Ref-08295	Annual Report Filing Fees	01/03

(2) Form OIR-B2-1507, Form OIR-B2-1507A, and Form OIR-B2-1356 as incorporated in rule 690-149.022, F.A.C., are also used for purposed of this rule chapter.

(3) Copies of all forms listed in subsection (1), above, may be obtained from the Office of Insurance Regulation's website: <http://www.florir.com/portal>.

Rulemaking Authority 624.308(1), 641.36 FS. Law Implemented 624.424, 627.410(6), (7), 627.413(4), 627.4145, 627.6699(12), 627.6735, 627.682, 627.9407(2), 628.4615, 641.19(13)(d), 641.21(1), 641.26(1), (2), 641.29 FS. History—New 2-22-88, Amended 10-25-89, Formerly 4-31.107, Amended 5-28-92, 8-15-94, 8-15-02, Formerly 4-191.107, Amended 7-30-17.



OFFICE OF INSURANCE REGULATION
Bureau of Life & Health Forms and Rates

SMALL EMPLOYER CARRIER'S APPLICATION TO BECOME A RISK ASSUMING CARRIER OR A REINSURING CARRIER, AS REQUIRED BY SECTION 627.6699(9), FLORIDA STATUTES

CARRIER NAME _____

ADDRESS (CITY/STATE/ZIP) _____

FEIN: _____ NAIC GROUP CODE: _____ NAIC COMPANY CODE: _____

As required under the provisions of Section 627.6699(11), Florida Statutes, we hereby apply to elect the following status. (Select one block only.)

☐ **A. Reinsuring Carrier**

A reinsuring carrier, as the term is used in Section 627.6699, Florida Statutes, is a direct writer of small employer health benefit plans and participates in the small employer health reinsurance program created by Section 627.6699 (11). If reinsuring carrier status is elected, nothing further is required except completion of the signature line on page 2 and submission to the Office.

☐ **B. Risk Assuming Carrier**

If risk-assuming carrier status is elected, attach information showing that the carrier is financially capable of assuming that status pursuant to the criteria in items 1 through 4, below; then complete the signature line at the bottom of the page and send to the Office, Bureau of Life and Health Forms and Rates.

1. The carrier's financial ability to support the assumption of risk of small employer groups. The carrier shall demonstrate that its surplus is adequate to support the fair marketing required by the act and that the planned premium volume after becoming a risk-assuming carrier does not endanger the financial condition of the carrier or endanger the interest of the carrier's policyholder.
2. The carrier's history of rating and underwriting small employers groups. The carrier shall demonstrate that it has successfully engaged in the business of transacting rating and underwriting of small employer groups or is the wholly owned subsidiary of such a company and that its condition and methods of operation in connection with small employer group contracts will not be such as to render its operation hazardous to the public or its policyholders in this state.
3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable. The carrier shall include a statement that the applicant has read and will comply with Section 627.6699 (13), Florida Statutes, Standards to Assure Fair Marketing. The Office shall consider the character, responsibility and general fitness of the officers and directors and the past market conduct of the carrier or its representatives.
4. The carrier's ability to assume and manage the risk of enrolling without the protection of the reinsurance program provided by Section 627.6699 (11), Florida Statutes. The Office shall consider the history and financial condition of the company. It should be demonstrated that the financial condition of the carrier is adequate to assume the risk of marketing or their employees' health status to comply with the purpose and intent of the law as stated in Section 627.6699 (2) without the benefit of the special reinsurance program created by Section 627.6699 (11) for reinsuring carriers. If part of the response is that your existing reinsurance program will be depended upon to cover such risks that you may be required to assume, include a copy of the reinsurance treaty with a summary of how it applies to these risks. The requirement of a copy of the reinsurance treaty does not apply to carriers that have a policyholder surplus in excess of \$100,000,000.

- ☐ **C. Not Applicable:** The carrier will not issue health benefit plans or products to Florida small employer groups as defined in Section 627.6699, Florida Statutes.

Signature of Officer

Date

Name of Officer

Position or Title

PLEASE TYPE OR PRINT DATE, POSITION OR TITLE, AND NAME OF OFFICER

Form OIR-B2-1093 to be submitted as follows:

Office of Insurance Regulation
Bureau of Life & Health Forms and Rates
Larson Building
Tallahassee, FL 32399-0328



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail ONLY completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL



Office of Insurance Regulation
Company Admissions

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

This package is designed to assist individuals in preparing the application with all the information required by statute and to facilitate expeditious processing of the application by this Office.

PLEASE NOTE: THE COMPLETED CHECK LIST MUST BE SUBMITTED WITH THE APPLICATION PACKAGE.

The completed application package must be submitted to the Office by utilizing the following link:

<http://www.floir.com/iportal>

and select iApply – Online Company Admissions

If this package requires submission of forms and/or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <http://www.floir.com/iportal> and select “Form & Rate Filing Assembly and Submission” to begin the submission of forms and/or rates.

If this package requires original documents, in lieu of providing original paper documents, the Applicant is directed to submit a PDF of the original document(s) unless otherwise required by Florida Statutes.

Any questions concerning this application package or iApply may be directed to lhappcoord@floir.com.

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Pursuant to Section 641.2015 and 641.19, Florida Statutes, in order to qualify as a Health Maintenance Organization, an entity must:

- A. Be incorporated or be a division of a corporation formed under the provisions of either chapter 607 or Chapter 617, or shall be a public entity that is organized as a political subdivision. [s. 641.2015, F.S.];
- B. Provide emergency care, inpatient hospital services, physician care including care provided by physicians licensed under Chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services. [s.641.19(12)(a), F.S.];
- C. Provide either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis. [s.641.19(12)(b), F.S.];
- D. Provide either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract. [s.641.19(12)(c), F.S.];
- E. Provide physician services, by physicians licensed under Chapters 458, 459, 460 and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians. [s.641.19(12)(d),F.S.]; and
- F. If an HMO offers services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or Chapter 459 and Chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network [s.641.19(12)(e), F.S.]

Although a pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office. To schedule a conference, please email lhappcoord@flor.com or call (850) 413-2512.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

**INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM**

Section I-1 Application Fee

The application filing fee is \$1,000. [s.641.29(1),F.S.]

Secure the check to the invoice, which is included in this package, and send to:

Department of Financial Services
Bureau of Financial Services
PO Box 6100
Tallahassee, Florida 32301-0315

Submit a copy of the invoice and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Processing Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure for instructions.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Section I-3 Deposits and Assessments

- A. Submit a check for \$10,000 made payable to " Commissioner of Insurance Regulation, State of Florida-Rehabilitation Administrative Expense Fund" to comply with Section 641.227(1), Florida Statutes. Mail the check to:

Department of Financial Services
Revenue Processing Section
PO Box 6100
Tallahassee, Florida 32314-6100

Submit a copy of the invoice and a copy of the check with your application filing.

- B. Submit a check for \$25,000 made payable to "Florida HMO Consumer Assistance Plan" to cover the special assessment required by Section 641.228(1), Florida Statutes. Mail the check to:

Bruce D. Platt, Plan Manager
201 E. Park Ave, Suite 300
Tallahassee, FL 32301
(850) 425-1628

Submit a copy of your transmittal letter to the Plan Manager and the check with your application filing.

Section I-4 Application for Certificate of Authority (Official Form Attached)

An original signature by the president or chief executive officer and one other authorized officer must appear on the application form under corporate seal.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit Articles of Incorporation and all amendments certified by the Florida Secretary of State's office. The certification must be an original.

Section II-2 Certificate of Status from Florida Secretary of State

Submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing. You may contact the Florida Secretary of State's office at (850) 245-6052 for further information in obtaining this certificate.

Section II-3 Company Bylaws

Submit a copy of the company's bylaws, rules and regulations or similar form of document, if any, regulating the conduct of the affairs of the applicant. These documents must be accompanied by a Board Resolution signed and dated by the secretary of the corporation, stating that the documents are a true and correct copy. The signature must be original and under the company's corporate seal.

Section II-4 Health Care Provider Certificate

Submit documentation demonstrating that the entity has filed an application for a Health Care Provider Certificate to be issued by the Agency for Health Care Administration (AHCA) pursuant to Chapter 641, Part III, Florida Statutes. Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that the application has been received by them.

NOTE: The Office will begin its review of an application for a Certificate of Authority any time after an organization has filed an application for the certificate with the Agency for Health Care Administration. The Office shall not issue a Certificate of Authority to any applicant, which does not possess a valid Health Care Provider Certificate. Once the Health Care Provider Certificate is issued, a copy must be provided to the Office of Insurance Regulation.

Section II-5 Authorization Letter

A letter of authorization is required for anyone other than company personnel or the company sponsoring agent, designating the named individual to represent the applicant.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Insurance

- A. Furnish evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising from the provision of health care services. If not self-insured, submit executed copies of the following policies, with the Office of Insurance Regulation listed on the policies for purposes of notification of any modification, cancellation or termination of the policies:
- (1) General liability
- (2) Medical malpractice or professional liability. The HMO must secure this coverage. The fact that the medical provider has this coverage does not release the HMO from the obligation to secure it. A binder for the policies along with a specimen copy of each policy can be submitted initially. Prior to licensure, executed copies of the policies must be submitted.
- B. Furnish a photocopy of an executed fidelity bond in the minimum amount of \$100,000, issued by an **authorized insurance carrier** in this State and covering all employees handling funds.
- C. Describe how the HMO limits or proposes to limit its financial risk. If the HMO secures catastrophic or reinsurance coverage, it is required to submit executed copies of the applicable policy with the Office of Insurance Regulation. Any reinsurance agreement must comply with Section 624.610, Florida Statutes and Rule 69O-144, Florida Administrative Code.

NOTE: Describe any risk sharing arrangements with providers or any other parties. Reference by application page number, the application sections of any provider contracts, which demonstrate the sharing of risk between the HMO and providers.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Section III-2 Financial Statements

- A. Provide a copy of the most recent audited certified public accountant's report prepared on the basis of statutory accounting principles. If the applicant is a development stage company that has not begun operations, an audited balance sheet should be provided. The financial statements should reflect sufficient surplus to meet the requirements of s. 641.225, Florida Statutes.
- B. Provide all quarterly financial statements covering the current year-to-date reporting period signed by the company's officers under notary seal.

Section III-3 Plan of Operations

Provide a statement generally describing present and proposed operations. State whether the HMO will be organized for profit or not for profit and whether it will be a Staff Model, IPA Model, or Combination Model HMO. Also, identify the HMO's fiscal year end date. The plan of operations should be for the greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.

If the HMO intends to market to small groups as defined by the Employee Health Care Access Act, s. 627.6699, Florida Statutes, please complete and submit the attached small employer carrier's application.

If the plan of operation indicates that the HMO will receive Medicaid funds, list all contracts and agreements and any information relative to any payment or agreement to pay, directly or indirectly, a consultant fee, a broker fee, a commission, or other fee or charge related in any way to the application for a certificate of authority or the issuance of a certificate authority. Such list shall provide the following, including, but not limited to, the name of the person or entity paying the fee; the name of the person or entity receiving the fee; the date of payment; and a brief description of the work performed.

Section III-3(a) Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, and advertising media to be used. Include a statement describing with reasonable certainty the geographic area or areas to be served by the HMO. Identify competing HMOs operating in the same geographic service area, as well as the market penetration of each. Also, identify the major differences between the applicant HMO and its competitors.

APPLICATION FOR CERTIFICATE OF AUTHORITY HEALTH MAINTENANCE ORGANIZATION

Section III-3(b) Pro Forma Statements

Submit a pro forma balance sheet and income statement on a statutory basis at monthly intervals (with an annual total) for a minimum three-year period (greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.) All assumptions used in deriving the pro forma statements must be provided. A Statement of Changes in Financial Position and a Statement of Cash Flows should be provided for the three-year period (or break-even), as well.

Section III-3(c) Statement of Initial Cash

Submit a statement of the proposed initial cash and cash reserves summary, including loan receipts, loan repayments, stock sales, etc. Also, describe the sources and terms of the funding. In the case of guaranteeing organizations, audited financial statements should be submitted for these entities.

Section III-3(d) History

Provide a brief history of the company since its incorporation. Include any predecessor corporations or organizations, mergers, reorganizations, or changes of ownership. Specify the parties and dates involved.

Section III-3(e) Insolvency Protection

Provide the method in which the applicant will comply with the insolvency protection requirements of Section 641.285, Florida Statutes, including all relevant documentation necessary to meet the requirements. Each HMO must comply with the insolvency protection requirements of Florida law. This is accomplished through a deposit with the Office of Insurance Regulation in the amount of \$300,000.00.

Section III-3(f) Contingency Plans

Provide any contingency plans for additional capital should the HMO fail to maintain minimum surplus requirements as mandated by Section 641.225, Florida Statutes.

APPLICATION FOR CERTIFICATE OF AUTHORITY HEALTH MAINTENANCE ORGANIZATION

Section III-3(g) Feasibility Study

Submit a comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant, which includes a rate and financial analysis, as well as enrollment projections and assumptions and competitor information. The study shall be for the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months. The study shall show that the HMO will maintain, at all times, the minimum surplus required by Section 641.225, Florida Statutes, and will not, at the end of any month of the projection period, have less than the minimum surplus as required by Section 641.225, Florida Statutes. The feasibility study shall contain an opinion by the CPA and actuary performing the study which shall opine as to the reasonableness of the assumptions used in the feasibility study and that the assumptions are reasonably applied.

The financial portion of the study shall be prepared in accordance with standards promulgated by the American Institute of Certified Public Accountants in its "Guide for Prospective Financial Statements" and opined accordingly. The actuarial portion of the study shall be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly. The feasibility study shall contain nothing less than an "examination opinion."

Section III-4 **Contracts**

- A. A copy of each type of contract made, or to be made, between the applicant and any providers (i.e hospitals, physicians, physician groups) regarding the provision of health care services to enrollees. All such contracts shall comply with Section 641.315, Florida Statutes.

- B. A copy of the form of any contract made or to be made between the applicant and senior management employment, as well as any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health care services to enrollees. All such contracts shall comply with Section 641.234, Florida Statutes and 641.315, F.S. if applicable.

Section III-5 **Grievance Procedure**

A statement describing the HMO's grievance procedure that will facilitate the resolution of subscriber grievances. The grievance procedure must include both formal and informal steps for resolving grievances and must be in compliance with all requirements set forth in Rule 4-191.078 (1 - 12), F.A.C., s.641.21(1)(e), & s. 641.22(9), F.S.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Section III-6 Bankruptcy Proceedings

Submit evidence of compliance with Section 641.215, Florida Statutes. This documentation should contain:

- A. An acknowledgment that a delinquency proceeding pursuant to Part I of Chapter 631 or supervision by the Office pursuant to s. 624.80-624.87, Florida Statutes, constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a health maintenance organization.
- B. A waiver of any right to file or be subject to a bankruptcy proceeding; and
- C. An acknowledgment that the commencement of a bankruptcy proceeding either by or against a health maintenance organization shall, by operation of law, terminate the health maintenance organization's certificate of authority and vest in the Office for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the insurer held by the Office.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION IV - MANAGEMENT

NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES.

Section IV-1 List of All Officers, Directors and Stockholders

- A. List the names, addresses and official positions of each officer, director and person having direct or indirect control of the organization, including but not limited to contracted management company personnel (form enclosed).
- B. List the names of each stockholder owning five percent or more of voting securities of the applicant or any person having the right to acquire in excess of ten percent of the voting securities of the applicant (issued and outstanding warrants/options, etc.). Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the HMO, including any possible conflicts of interest.
- C. If the applicant is a subsidiary of a parent or holding company, provide an organizational chart showing the relationship of all related companies.

Section IV-2 Biographical Affidavits for Officers, Directors and Stockholders

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered.

The requirements for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the Biographical Affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also, please mark CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Section IV-3 Background Investigative Reports

A Background Investigative Report must be provided for each person listed in Section IV-1 above except for those companies in the organizational structure between the immediate parent and the ultimate parent. Background reports must be submitted by the selected background investigator vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Please refer to Form OIR- C1-905 for instructions.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in Section IV-1. **No fingerprint cards other than those furnished by the Office will be accepted.** The cards will be furnished by the Office upon request. These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Please refer to Form OIR-C1-938, Fingerprint Payment and Submission Procedure for instructions.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION V - FORMS AND RATES

Note: submit three (3) original copies of each referenced form and rate filing.

Section V-1 Forms

- A. Submit three copies of each policy, master contract, certificate of coverage, member handbook, application, or any other form the applicant proposes to offer the subscriber. This includes any form showing the benefits to which the subscriber is entitled and any form used in the enrollment process. Every form which the HMO will use in connection with its subscriber contracts must be submitted and must be identified by a unique form number located on the lower left corner of the form.
- B. Each subscriber contract must state the procedures for offering comprehensive health care services and offering and terminating contracts to subscribers which will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status.

Section V-2 Rates

- A. Submit three copies of the complete schedule of proposed premium rates for each type of contract. The submission for each separate contract should contain an opinion from a qualified independent actuary. The opinion shall:
 - (1) Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
 - (2) Certify that the rates are appropriate for the classes or risks for which they have been computed;
 - (3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.
- B. Furnish a statement from a qualified independent actuary that the HMO is actuarially sound.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

**CHECK LIST
SECTION I - APPLICATION FEES AND FORM**

Company Name: _____

<u>Item #</u>		<u>Completion Check List</u>
1.	Application Fees Paid	☐
	(a) Copy of invoice included (Official Form)	☐
	(b) Copy of check included	☐
	(c) Check mailed to address on Invoice	☐
2.	Fingerprint fee paid electronically	☐
	(a) Copy of on-line payment confirmation	☐
3.	Deposits and Assessments	☐
	(a) Copy of \$10,000 check and copy of Invoice	☐
	(b) Copy of \$25,000 check and copy of cover letter	☐
4.	Application for Certificate of Authority (Official Form)	☐
	(a) Application form completed	☐
	(b) Sealed by corporation	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

<u>Item #</u>		<u>Completion Check List</u>
(c)	Signed by President and other authorized officer (original signature)	☐
(d)	Notarized	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION II - LEGAL

<u>Item #</u>		<u>Completion Check List</u>
1.	Articles of Incorporation	☐
	(a) Original certification by Florida Secretary of State	☐
	(b) Articles with all amendments attached	☐
2.	Certificate of Status from Florida Secretary of State, signed by proper public official (original document)	☐
3.	Corporate bylaws, rules and regulations, and/or Constitution	☐
	(a) Signed and dated by corporate secretary	☐
	(b) Corporate seal affixed.....	☐
	(d) Board Resolution	☐
4.	Health Care Provider Certificate	☐
	Documentation of a Health Care Provider Certificate or proof of a pending application with AHCA	☐
5.	Outside Representative Authorization Letter	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION III - FINANCIAL AND RELATED INFORMATION

<u>Item #</u>		<u>Completion Check List</u>
1.	Insurance	☐
(a)	Copy of current general liability policy or plan for self-insurance	☐
	and Current medical malpractice policy or plan for self-insurance	☐
(b)	Evidence of current fidelity bond	☐
(c)	Reinsurance treaty	☐
2.	Financial Statements	☐
(a)	Current audited financial statements	☐
(b)	Quarterly financial statement	☐
3.	Plan of Operations	☐
	(Small Employer Carrier Application, if applicable)	☐
(a)	Marketing and Growth	☐
(1)	Description of marketing methods	☐
(2)	A statement describing the applicant, facilities and personnel, etc	☐
(3)	Statement of geographic area to be served	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY HEALTH MAINTENANCE ORGANIZATION

<u>Item #</u>	<u>Completion Check List</u>
(b) Pro Forma Statements	☐
(1) Balance sheet	☐
(2) Income statement	☐
(3) Cash flow analysis	☐
(4) Change in financial position	☐
(c) Statement of Initial Cash	☐
Provisions for contingencies	☐
(d) History	☐
(e) Insolvency Protection Deposit with the Office	☐
(1) Deposit with the Office	☐
or	
(2) Reinsurance Policy	☐
or	
(3) Guarantee Arrangement	☐
(f) Contingency Plans	☐
(g) Feasibility study	☐
4. Contracts	☐
(a) Provider contract form and signature pages	☐
(b) Other forms of contracts	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

<u>Item #</u>		<u>Completion Check List</u>
5.	Grievance Procedure	☐
	(a) Formal and informal steps included	☐
6.	Bankruptcy Proceedings	☐
	(a) Acknowledgement filed	☐
	(b) Waiver for bankruptcy proceeding	☐
	(c) Acknowledgement for bankruptcy proceeding	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION IV - MANAGEMENT

<u>Item #</u>	<u>Completion Check List</u>
1. Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-1298).....	☐
2. Listing of all immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298).	☐
3. Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298). Note, do not complete Form OIR-C1-1423 (Biographical Affidavits), or order investigative reports or fingerprint cards.....	☐
4. Listing of all ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
5. Organizational Chart including all entities within the ultimate parent company structure	☐
6. Biographical Affidavits for company officers, directors and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1298)	☐
As to each biographical:	
(a) All blanks completed	☐
(b) "Yes" answers explained	☐
(c) Contains original signature	☐
(d) Notarized (original)	☐
(e) Original of each affidavit submitted.....	☐
(f) SSN on a separate page.....	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

<u>Item #</u>		<u>Completion Check List</u>
7.	Biographical Affidavits for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent Company's stock (Form OIR C1-1423).....	☐
	As to each biographical:	
(a)	All blanks completed	☐
(b)	"Yes" answers explained	☐
(c)	Contains original signature	☐
(d)	Notarized (original)	☐
(e)	Original and one copy of each affidavit submitted	☐
(f)	SSN on a separate page.....	☐
8.	Biographical Affidavits for ultimate parent(s) officers, directors and Shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1423)	
	As to each biographical:	
(a)	All blanks completed	☐
(b)	"Yes" answers explained	☐
(c)	Contains original signature	☐
(d)	Notarized (original)	☐
(e)	Original and one copy of each affidavit submitted	☐
(f)	SSN on a separate page.....	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

9. Background investigative reports for company officers, directors and shareholders (including entities) owning 10% or more of applicant..... ☐
10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock..... ☐
11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock..... ☐
12. Fingerprint cards enclosed for each company officer, director, and shareholder (including entities) owning 10% or more of applicant ☐

As to each fingerprint card:

- (a) Contains original signature ☐
- (b) Florida cards only ☐
- (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ☐
13. Fingerprint cards enclosed for each immediate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

As to each fingerprint card:

- (a) Contains original signature ☐
- (b) Florida cards only ☐
- (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ☐
14. Fingerprint cards enclosed for each ultimate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

As to each fingerprint card:

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

- (a) Contains original signature ☐
- (b) Florida cards only ☐
- (c) All information completed (DOB, citizenship,
vital statistics, SSN on a separate page) ☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

SECTION V - FORMS AND RATES

<u>Item #</u>		<u>Completion Check List</u>
1.	Forms	☐
	(a) 3 copies of each form	☐
	(b) Identified by unique form number	☐
2.	Rates	☐
	(a) 3 copies of each rate schedule and or contract placed with original application	☐
	(b) Rates are neither inadequate, excessive, nor unfairly discriminatory	☐
	(c) Rates are appropriate for class	☐
	(d) Description of rating methodology	☐
	(e) Statement from a qualified actuary that the HMO is actuarially sound	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by _____, that

(Entity Name)

he/she has read said application, that he/she knows the contents thereof and verifies that the items indicated in the application checklist have been submitted with the application, that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the applicant on behalf which the person acted, executed the instrument.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes.

Dated _____
(Give full and exact name of Applicant)

Signature of President, Secretary, or Treasurer

Printed Name

Printed Title

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Pursuant to Chapter 641, Part I, Florida Statutes, application is hereby submitted to form and operate a Health Maintenance Organization.

Proposed name of Health Maintenance Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

SOLVENCY CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a Health Maintenance Organization in the state of Florida, under the laws thereof, and do hereby swear or affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

Page 1 of 2

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

APPLICATION CERTIFICATION

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to acquire a Florida insurer, either directly, indirectly, or via merger; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

(Corporate Seal)

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 2020, by _____
(name of person)

as _____ for _____
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

INVOICE

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

FEIN#: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

(CITY) (STATE) (ZIP CODE)

In reference to the submission of the above-referenced insurer's application to do business in Florida, it is necessary for this form to be returned with proper payment.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail check and invoice only to the Florida Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

For Accounting Use Only

=====

<u>B/T</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
C	12/47	F	\$1,000



Department of Financial Services
Office of Insurance Regulation

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

REHABILITATION ADMINISTRATIVE EXPENSE FUND
(Pursuant to Section 641.227, F.S.)

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

FEIN: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

In reference to the submission of the above-referenced Health Maintenance Organization's Application for Certificate of Authority to do business in Florida, it is necessary for this form to be returned to the address below with proper payment.

PLEASE NOTE:

1. Send a check in the amount indicated, made payable to the Department of Financial Services, and mail the check and invoice to the Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and a copy of the invoice with the completed application package that is submitted to the Office of Insurance Regulation, Application Coordination Section, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

For Accounting Use Only

=====

<u>B/T</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
C	12/00	A	\$10,000

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

2. a. Are you a citizen of the United States?

Yes ☐ No ☐

b. Are you a citizen of any other country?

Yes ☐ No ☐

If yes, what country? _____

3. Affiant's occupation or profession: _____

4. Affiant's business address: _____

Business telephone: _____ Business Email: _____

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Present or proposed position with the Applicant Company: _____

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐ No ☐

If any claims were made on the bond, give details: _____

- b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐ No ☐

If yes, give details: _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

- a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes ☐ No ☐

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

- b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
- Yes ☐ No ☐
- c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
- Yes ☐ No ☐
- d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
- Yes ☐ No ☐
- h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
- Yes ☐ No ☐
- i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
- Yes ☐ No ☐
- j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
- Yes ☐ No ☐

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person,

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details. _____

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☐

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details: _____

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☐

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☐

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Yes ☐ No ☐

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

**BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information**

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____
IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS
COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☐

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

4. Government Identification Number if not a U.S. Citizen: _____

5. Foreign Student ID# (if applicable) : _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. Date of Birth: (MM/DD/YY) : _____ Place of Birth, City: _____
State/Province: _____ Country: _____

7. Name of Affiant's Spouse (if applicable) : _____

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

___ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[name of CRA, address]** (“CRA”). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency (“CRA”) by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.” You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

OIR-C1-2221

Rev: 6/20

Rule 690-191.027

69O-192.001 Purpose and Scope.

Rulemaking Authority 624.4431 FS. Law Implemented 624.436 FS. History—New 7-15-90, Formerly 4-116.001, Amended 11-16-92, Formerly 4-192.001, Repealed.

69O-192.008 Multiple-Employer Welfare Arrangement Application ~~General Eligibility~~.

Substantial rewording of Rule 69O-192.008, F.A.C. follows. See Florida Administrative Code for present text.

(1) An application for a person applying for a certificate of authority as a multiple-employer welfare arrangement consists of the following:

(a) Form OIR-C1-983, “Application for Certificate of Authority Multiple Employer Welfare Arrangements,” effective 2/22, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(b) Form OIR-C1-905, “Instructions for Furnishing Background Investigative Reports,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(c) Form OIR-C1-938, “Fingerprint Payment and Submission Procedures,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(d) Form OIR-C1-1423, “Biographical Affidavit,” effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX; and

(e) Form OIR-C1-2221, “Management Information Form,” effective 6/20, available at www.flrules.org/XXXXX.

(2) A person applying for a certificate of authority as a multiple-employer welfare arrangement shall submit forms in subsection (1) as directed by the Office electronically at <https://www.flair.com/iportal>.

Rulemaking Authority ~~624.439~~, 624.4431 FS. Law Implemented ~~624.438(1)(a), (b)~~, ~~624.439(7)(a)~~ FS. History—New 7-28-94, Formerly 4-192.008, Amended.

69O-192.048 Annual and Quarterly Reporting Requirements ~~Report~~.

Substantial rewording of Rule 69O-192.048, F.A.C. follows. See Florida Administrative Code for present text.

(1) Each Multiple Employer Welfare Arrangements (“MEWA”) shall file with the Office a full and true report of its financial condition, transactions, and affairs.

(a) An annual report covering the preceding fiscal year shall be filed within 3 months after the end of the fiscal year, and quarterly reports within 45 days after the end of each of its four quarterly reporting periods.

(b) The Office shall grant an extension of time for filing an annual or quarterly report if there exist conditions beyond the control of the authorized MEWA, such as rehabilitation pursuant to chapter 631, F.S., or the laws of the state of domicile; severe damage to the MEWA’s physical premises by a natural or man-made disaster; or some other reason of similar gravity and severity. The request for an extension of time for filing an annual or quarterly report shall be submitted to the Office at least 7 days before the filing is due. The extension shall be for the amount of time reasonable to file under the conditions which justified the extension.

(c) For purposes of this rule, the requirement that reports be filed with the Office means that the report has been transmitted electronically to the National Association of Insurance Commissioners and that the executed Jurat page of said report has been transmitted electronically to the Office via the Regulatory Electronic Filing System, “REFS.” The date affixed by the Office’s electronic data processing system shall serve as evidence of the timeliness of the report. Annual and quarterly reports in any other format shall not be submitted to the Office.

(2) Annual and Quarterly Report Reporting.

Each MEWA shall submit its annual and quarterly report information electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions incorporated by reference in paragraph 69O-137.001(3)(b), F.A.C.

(3) Manuals Adopted.

(a) Annual reports shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(a), F.A.C.

(b) Quarterly reports shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(b), F.A.C.

(c) Copies of the manuals are available:

1. From the National Association of Insurance Commissioners at <http://www.naic.org>; and,

2. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.

Rulemaking Authority 624.442, 624.4431 FS. Law Implemented 624.442~~(4)~~ FS. History—New 11-16-92, Formerly 4-192.048, Amended_____.

69O-192.058 Forms Incorporated by Reference.

Rulemaking Authority 624.4431 FS. Law Implemented 624.424, 624.439, 624.442, 628.4615 FS. History—New 7-15-90, Formerly 4-116.015, Amended 7-28-94, Formerly 4-192.058, Amended 7-30-17, Repealed_____.



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail **ONLY** completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL



Florida Office of Insurance Regulation

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in searchable PDF format unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting Company Admissions – iApply Login at the following link:

<https://www.floir.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

INSTRUCTIONS

SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fees

Applicants must pay a filing fee of \$1,500 USD, pursuant to Section 624.501(1)(a), Florida Statutes. The fee is due at the time the application is filed and not refundable.

Secure your check to the Invoice on page 18 of this application and mail to:

Florida Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

Include copies of the completed Invoice and check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions.

Section I-3 Application Certification

The Application Certification on page 17 must be completed by two officers, notarized, and submitted with the application.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

SECTION II – LEGAL

Section II-1 Organizational Documents of Sponsoring Association

Submit a copy of the sponsoring association's organizational or charter documents, such as Articles of Incorporation, Partnership Agreements, etc., complete with all amendments, certified within the last year by the public official with whom the originals are on file in the state or jurisdiction of domicile. If the originals are not required to be on file with a public official in the state or jurisdiction of domicile, then the copies should be certified by an appropriate representative of Applicant. If the sponsoring association is not incorporated, and has no similar organizational documents, please provide a statement that no such documents exist.

Section II-2 Florida Certificate of Status of Sponsoring Association

Submit a Florida certificate of status for the sponsoring association dated within the last year. This document is not required if the sponsoring association is not incorporated or otherwise required to be registered as a legal entity.

Section II-3 Bylaws of Sponsoring Association

Submit a copy of the sponsoring association's Bylaws, Operating Agreement, Constitution, Rules and Regulations, or similar document. This should be certified by sponsoring association's Secretary as a true and correct copy of the current document and dated within the last year. Only the Secretary's signature will be accepted, unless the sponsoring association does not have this position. If the sponsoring association does not have Bylaws, an Operating Agreement, Constitution, Rules and Regulations, or similar organizational document, please provide a statement that no such documents exist.

Section II-4 Organizational Documents of the Arrangement

Submit a copy of the arrangement's organizational or charter documents, such as Articles of Incorporation, Partnership Agreements, etc., complete with all amendments, certified within the last year by the public official with whom the originals are on file in the state or jurisdiction of domicile. If the originals are not required to be on file with a public official in the state or jurisdiction of domicile, then the copies should be certified by an appropriate representative of Applicant. If the arrangement is not incorporated, and has no similar organizational documents, please provide a statement that no such documents exist.

Section II-5 Florida Certificate of Status of the Arrangement

Submit a Florida certificate of status for the arrangement dated within the last year. This document is not required if the arrangement is not incorporated or otherwise registered as a legal entity.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Section II-6 Bylaws of the Arrangement

Submit a copy of the arrangement's Bylaws, Operating Agreement, Constitution, Rules and Regulations, or similar document. This should be certified by the arrangement's Secretary as a true and correct copy of the current document and dated within the last year. Only the Secretary's signature will be accepted, unless the arrangement does not have this position. If the arrangement is not incorporated, and has no similar organizational documents, please provide a statement that no such documents exist. If the arrangement does not have Bylaws, Rules and Regulations or similar organizational document, please provide a statement that no such documents exist.

Section II-7 Trust Agreement Establishing the Arrangement

Provide a copy of the Trust Agreement by which the sponsoring association establishes the arrangement and its operations. The Trust Agreement must be signed by all of the trustees.

If the Trust Agreement or Bylaws do not specifically indicate the following, please attach other documents that establish the following and indicate where in the documents these provisions may be found:

1. The board of trustees shall have complete fiscal control over the arrangement;
2. The board of trustees shall be responsible for all operations of the arrangement;
3. The trustees selected shall be owners, partners, officers, directors, or employees of one or more employers in the arrangement;
4. A trustee may not be an owner, officer, or employee of the administrator or service company of the arrangement; and
5. The trustees shall have the authority to approve applications of association members for participation in the arrangement and to contract with an authorized administrator or service company to administer the day-to-day affairs of the arrangement.

Section II-8 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Financial Requirement

Existing arrangements must submit a copy of its most recent IRS Federal Form 5500, Annual Return/Report of Employee Benefit Plan.

Section III-2 Plan of Operations

It is important for the Office to have a clear understanding of the proposed operations of the arrangement and the goals it seeks to achieve. To fulfill this requirement, submit a plan of operations that includes all of the components below.

- A. Current Operations: Applicant should identify the number of employers currently participating in the arrangement, the number of covered employees, and the number of covered dependents.
- B. Management: Provide the name and address of the employer of each trustee and indicate which of the following positions the trustee holds with that employer: owner, partner, officer, director, or employee.

Applicant should also list the individuals responsible for managing or handling funds or assets of the arrangement.

- C. Administration: Provide the name of the service company or third party administrator responsible for servicing the program of the arrangement and attach a copy of the company's Florida license.

Attach a copy of the agreement between the service company or administrator and the trust. This agreement should be signed by the administrator and trustee.

- D. Claims Adjusting and Underwriting: Describe Applicant's plan for administering the arrangement, including the qualifications and amount of staff that will be required to service the program in the areas of claims adjusting, underwriting, and billing. The criteria for underwriting should be justified, and a description of procedures for a special health test pursuant to Section 627.429(4), Florida Statutes, should be included.
- E. Marketing and Growth: Provide an outline and description of management's marketing efforts.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Section III-3 Fidelity Bond

In this section, provide a copy of the fidelity bond issued in the name of the arrangement covering its trustees, directors, officers, employees, administrator, or other individuals managing or handling the funds or assets of the arrangement. The bond should be in an amount not less than 10% of funds handled annually, but in no case may it be less than \$50,000 USD or more than \$500,000 USD, except for as provided in Section 624.439(5), Florida Statutes.

Section III-4 Excess Insurance Agreement

Submit a copy of the present or proposed excess insurance agreement/policy, which should provide that the net retention level for any one risk not exceed \$50,000 USD, and which shall otherwise be in accordance with sound actuarial principles. In addition to the agreement, please submit a summary of the agreement with enough detail to describe the nature of the coverage.

If Applicant would like to request a waiver or modification of the maximum net retention requirement, please provide evidence of the conditions set forth in Section 624.439(6)(b), Florida Statutes.

Section III-5 Fund Balance

Provide evidence that the arrangement has a fund balance equal to \$200,000 USD, which is in addition to the required statutory deposit. Evidence may include a current bank statement or a certified financial statement. The fund balance of at least \$200,000 USD should be reflected in the projections of the feasibility study.

Section III-6 Feasibility Study

The Applicant must submit a feasibility study done by an independent qualified actuary and an independent certified public (see Section V-3). The study should be for the greater of 3 years or until the arrangement has been projected to be profitable for 12 consecutive months.

The study must show that the arrangement would not, at any month-end of the projection period, have less than the minimum statutory deposit required by Section 624.441, Florida Statutes, or have a fund balance less than the amount required by Section 624.4392, Florida Statutes. The study must also reflect and support that initial gross premiums for the first year of operation will be at least \$100,000 USD, as required by Section 624.439(7)(b), Florida Statutes.

The feasibility study must include the following.

- A. A description of market potential, market penetration, and market competition.
- B. A current audited financial statement prescribed by Section 624.439(11), Florida Statutes, must be submitted for the proposed arrangement. The audited statement must be certified by an independent certified public accountant. If your group is already operating, submit an annual income statement developed on a statutory accounting principle basis for the past 5 years.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

NOTE: The current financial statement should include a balance sheet. If the organization is already in business, it should also include an income statement as well as a statement of changes in financial position. Each arrangement must demonstrate that it will have adequate funding to continually meet the minimum fund balance requirements of Section 624.4392, Florida Statutes. Surplus notes may be used in the calculation of surplus.

- C. Pro forma financial statements in Excel format including each of the following:
 - 1. A projected income statement on a monthly basis, with an annual total, through break even. The income statement should be for a minimum of 3 years and should be developed on a statutory accounting principle basis.
 - 2. A projected cash flow analysis on a monthly basis, with an annual total through break even for a minimum of 3 years. Line by line documentation must be submitted. The surplus/ deficit must be the amount used on the cash and cash reserves summary to reflect operations cash flow.
 - 3. A projected balance sheet annually through break even. The balance sheet should be for a minimum of 3 years and should be developed on a statutory accounting principle basis. It should be accompanied by statements of changes in financial position for the same time period.
- D. A statement of the proposed initial cash and cash reserves summary. This should be all inclusive (loan receipts, loan repayments, stock sales, etc). Also, include a description of the source and terms of the funding.
- E. The method in which the Multiple Employer Welfare Arrangement will comply with the insolvency protection deposit requirements of Section 624.441, Florida Statutes, including all relevant documentation necessary to meet the requirements. The deposit amount should be the greater of 5% of gross annual premiums for the succeeding year, or 25% of claims expenditures for the previous twelve months.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

SECTION IV - MANAGEMENT

Section IV-1 Management

- A. Applicant must submit an alphabetical list of the names, address, and official capacity/title (trustee, president, vice-president, secretary, treasurer, chief financial officer, etc) of the individuals who are to be responsible for the management and conduct of affairs of the arrangement. Including, but not limited to, all trustees, managers, officers, and directors. Names should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.
- B. All individuals listed in part A above must disclose to the Office the extent and nature of any contracts or other understandings or agreements between themselves and the arrangement, including any possible conflicts of interest.

Section IV-2 Biographical Affidavits

Provide a National Association of Insurance Commissioners ("NAIC") Biographical Affidavit (NAIC Form 11) (Form OIR-C1-1423) for each individual listed in Section IV-1. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

All questions must be answered. All "Yes" answers must be explained.

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Section IV-3 Background Investigative Report

A Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, included in this packet.

The NAIC approved background investigation vendor list can be found at:

https://www.naic.org/documents/industry_ucaa_third_party.pdf

Section IV-4 Fingerprint Cards

Fingerprint cards must be provided to the Office for each person for whom a Biographical Affidavit is required. Please refer to Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions. If an individual has submitted a fingerprint card dated within 5 years of the date of the Application filing, a fingerprint card need not be submitted for that individual.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

SECTION V - FORMS AND RATES

Section V-1 Forms

No business may be written until the Office has approved forms. Submit the policy, contract, certificate of coverage, summary plan description, and/or other evidence of the benefits and coverages provided to each covered employee.

Evidence of benefits and coverages must contain in bold faced print of at least 12-point type in a conspicuous location, the following statement:

The benefits and coverages described herein are provided through a trust fund established and funded by a group of employers. It is not an insurance company and is not protected by a guaranty fund in the event of insolvency. Participating employers are assessable for any losses incurred by the trust.

Each policy issued by the arrangement must contain a statement of the contingent liability. Both the application for insurance and policy shall contain, in contrasting color and not less than 10-point type, the following statement: "This is a fully assessable policy. In the event the arrangement is unable to pay its obligations, policyholders (employers) will be required to contribute on a pro rata earned premium basis the money necessary to meet any unfilled obligations."

Forms must also meet the Flesch score requirements of Section 627.4145, Florida Statutes.

Section V-2 Rates

Submit a complete schedule of proposed premium rates for each type of contract.

Section V-3 Actuarial Rate Analysis

Applicant should submit a report prepared by a certified actuary, who is a member of the Society of Actuaries or the American Academy of Actuaries. The report should provide evidence that the arrangement will be operated in accordance with sound actuarial principles, that proposed rates are not inadequate, that the rates are appropriate for the class of risks for which they have been computed, and that an adequate description of the rating methodology has been filed with the Office and such methodology follows consistent and equitable actuarial principles. The actuarial justification of rates should be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly. Specific elements that must be included are listed in item 3 on page 16 under Forms and Rates.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

CHECKLIST

Applicant Name: _____

Federal Identification Number: _____

Home Office Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

SECTION I - APPLICATION & FEES

- ☐ 1. Application fee paid
 - ☐ a. Copy of invoice included (page 20 of this form)
 - ☐ b. Copy of check included
- ☐ 2. All fingerprint fees paid electronically
 - ☐ a. Copies of online payment confirmation
- ☐ 3. Application Certification (page 17)
 - ☐ a. Two copies, each filled out by a different officer
 - ☐ b. Notarized

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Applicant Name: _____

SECTION II – LEGAL

- ☐ 1. Organizational Documents of Sponsoring Organization (if applicable)
 - ☐ a. Certified by public official within the last year
- ☐ 2. Florida Certificate of Status of Sponsoring Organization (if applicable)
 - ☐ a. Certified within the last year
- ☐ 3. Bylaws of Sponsoring Organization (if applicable)
 - ☐ a. Certified by Secretary within the last year
- ☐ 4. Organizational Documents of the Arrangement (if applicable)
 - ☐ a. Certified by public official within the last year
- ☐ 5. Florida Certificate of Status of the Arrangement (if applicable)
 - ☐ a. Certified within the last year
- ☐ 6. Bylaws of the Arrangement (if applicable)
 - ☐ a. Certified by Secretary within the last year
- ☐ 7. Trust Agreement Establishing the Arrangement
 - ☐ a. Signed by all trustees
 - ☐ b. Additional documentation establishing II-7 #1-5, if necessary
- ☐ 8. Authorization Letter (if applicable)

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Applicant Name: _____

SECTION III - FINANCIAL AND RELATED INFORMATION

- ☐ 1. Most recent IRS Federal Form 5500, Annual Return/Report of Employee Benefit Plan, if an existing arrangement.

- ☐ 2. Plan of Operations
 - ☐ a. Current Operations
 - ☐ i. Number of employers
 - ☐ ii. Number of employees
 - ☐ iii. Number of dependents
 - ☐ b. Management
 - ☐ i. Name and address of the employer of each trustee
 - ☐ ii. What position the trustee holds with their employer
 - ☐ iii. List of individuals responsible for managing or handling the arrangement's funds or assets
 - ☐ c. Administration
 - ☐ i. Name of Service Company or Administrator
 - ☐ ii. Copy of the Service Company or Administrator's Florida license
 - ☐ iii. Copy of the agreement between the Service Company or Administrator and the trust.
 - ☐ 1. Signed by the Service Company or Administrator and trustee.
 - ☐ d. Claims Adjustment and Underwriting
 - ☐ i. Description of plan for administering the arrangement
 - ☐ ii. Plan for servicing billings, claims, and underwriting
 - ☐ iii. Number of adjuster and underwriters
 - ☐ iv. Justification of underwriting criteria
 - ☐ v. Special health test procedures
 - ☐ e. Marketing and Growth
- ☐ 3. Fidelity Bond

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

- ☐ **4.** Excess Insurance Agreement
- ☐ **5.** Fund Balance
- ☐ **6.** Feasibility Study
 - ☐ **a.** Addresses market potential, market penetration, and market competition
 - ☐ **b.** Current audited financial statements
 - ☐ **c.** Projected income statement
 - ☐ **d.** Projected cash flow analysis
 - ☐ **e.** Projected balance sheet
 - ☐ **f.** Proposed initial cash and cash reserves summary
 - ☐ **g.** Insolvency protection deposit requirements

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Applicant Name: _____

SECTION IV – MANAGEMENT

- ☐ 1. Alphabetical list of all individuals as described in IV-1 (A)
 - ☐ a. Disclosure by all individuals as described in IV-1 (B)
- ☐ 2. Biographical affidavits (Form OIR-C1-1423) submitted for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. "Yes" answers explained
 - ☐ c. Signed
 - ☐ d. Notarized
- ☐ 3. Background investigative reports for all required individuals. The reports must be based on the Biographical Affidavits submitted to the Office with this Application.
 - ☐ a. Proof of order and confirmation of payment submitted to the Office
- ☐ 4. Fingerprint cards for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. Signed

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

Applicant Name: _____

SECTION V – FORMS AND RATES

- ☐ **1. Forms**
 - ☐ **a.** Contains assessability language
 - ☐ **b.** Contains statement of contingent liability
 - ☐ **c.** Meets Flesch score requirements
- ☐ **2. Complete schedule of proposed premium rates for each type of contract**
- ☐ **3. Actuarial Rate Analysis**
 - a.** Prepared by certified actuary
 - b.** Prepared in accordance with standards of the American Academy of Actuaries
 - c.** Includes description of assumptions
 - d.** Includes estimation of incurred but not reported claims (IBNR)
 - e.** Includes forecast of rates/claims
 - f.** Includes certification

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

APPLICATION CERTIFICATION

The below certification must be executed by two officers of the trust. Two completed copies of this page should be submitted with the application.

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to apply for a Certificate of Authority as a Multiple Employer Welfare Arrangement; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represents that they have the authority to bind the Applicant, and that by their signature on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20____, by _____
(name of person)

as _____ for _____
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT**

INVOICE

NAME OF ARRANGEMENT: _____

FEIN: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

MAILING ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS ABOVE):

(city) (state) (zip code)

1. Make payable to the Department of Financial Services and mail check and invoice only to:
Department of Financial Services,
Bureau of Financial Services,
Post Office Box 6100
Tallahassee, Florida 32314-6100
2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

RECEIPT	AMOUNT	TYPE	CLASS	FUND	ACCOUNT	SOURCE	NUMBER
	\$1,500	12	07	3	09		02

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: Form A UCAA Type: UCAA Type Other: Other

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Applicant Company Name

Address: Applicant Company Address

City: Applicant Company City

State/Province: State/Province

Postal Code: Postal Code

Phone: Phone

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name

2. a. Are you a citizen of the United States?

☐ Yes

☐ No

b. Are you a citizen of any other country?

☐ Yes

☐ No

If yes, what country? If yes, what country?

3. Affiant's occupation or profession: Affiant's occupation or profession

4. Affiant's business address: Affiant's business address

Business telephone: Business telephone

Business email: Business email

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>College/University (C/U)</u>	<u>C/U City/State</u>	<u>MM/YY-MM/YY</u>	<u>Degree Obtained</u>

<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Graduate Studies (GS)</u>	<u>GS College/University</u>	<u>GS City/State</u>	<u>MM/YY-MM/YY</u>	<u>GS Degree Obtained</u>

<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

<u>Other Training: Name (OT)</u>	<u>OT City/State</u>	<u>MM/YY-MM/YY</u>	<u>OT Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>

7. Present or proposed position with the Applicant Company: Present or proposed position with the Applicant Company

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

9. a. Have you ever been in a position which required a fidelity bond?

☐ Yes ☐ No

If any claims were made on the bond, give details: Give Details

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

☐ Yes ☐ No

If yes, give details: Give Details

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Question 10, Give Details

Organization/Issuer of License: Org/Issuer License

Address: Address

City: City

State/Province: State/Province

Country: Country

Postal Code: Postal Code

License Type: License Type

License #: License #

Date Issued (MM/YY): MM/YY

Date Expired (MM/YY): MM/YY

Reason for Termination: Reason for Termination

Non-Insurance Regulatory Phone Number (if known): Phone Number

Organization/Issuer of License: Org/Issuer License

Address: Address

City: City

State/Province: State/Province

Country: Country

Postal Code: Postal Code

License Type: License Type

License #: License #

Date Issued (MM/YY): MM/YY

Date Expired (MM/YY): MM/YY

Reason for Termination: Reason for Termination

Non-Insurance Regulatory Phone Number (if known): Phone Number

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

☐ Yes ☐ No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

☐ Yes ☐ No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

☐ Yes ☐ No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

☐ Yes ☐ No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

☐ Yes ☐ No

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

If yes, provide details including dates, locations, dispositions, etc.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

List any entity subject to regulation by an insurance regulatory authority that control directly or indirectly.

If any of the stock is pledged or hypothecated in any way, give details. Give details if stock is pledged or hypothecated.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

☐ Yes ☐ No

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

Provide Details.

If any of the shares of stock are pledged or hypothecated in any way, give details.

If shares are pledged or hypothecated, give details.

14. Have you ever been adjudged a bankrupt?

☐ Yes ☐ No

If yes, provide details: If yes, provide details.

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. Group Code(s).

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

☐ Yes ☐ No

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

☐ Yes ☐ No

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

If the answer to any of the above is yes, please indicate and give details.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Dated and signed this Day day of Month 20Year at Click or tap here to enter text.. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

 I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification..

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: Form A UCAA Type: UCAA Type Other: Other

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Applicant Company Name

Address: Applicant Company Address

City: Applicant Company City

State/Province: State/Province

Postal Code: Postal Code

Phone: Phone

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name
IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS
COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

☐ Yes ☐ No

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: XXX-XX-XXXX.

4. Government Identification Number if not a U.S. Citizen:

Government ID Number:

Govt. ID Number

Govt. ID Number

Govt. ID Number

Country of Issuance:

Country of Issuance

Country of Issuance

Country of Issuance

5. Foreign Student ID# (if applicable): Foreign Student ID Number

6. Date of Birth: (MM/DD/YY): MM/DD/YY

State/Province: State/Province

Place of Birth, City: Place of Birth, City

Country: Country

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

7. Name of Affiant's Spouse (if applicable): Name of Affiant's Spouse

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this Day day of Month, 20Year at Click or tap here to enter text.. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

 I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with a pending application of Company Name, [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through Name of CRA and Address, [name of CRA, address] ("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to Company's Designated Person, Position or Department, Address and Phone, [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By, and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

My Commission Expires

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

OIR-C1-2221

Rev: 6/20

Rule 690-192.008

CHAPTER 69O-194 PREPAID HEALTH CLINICS

69O-194.001	Scope
69O-194.002	Definitions
69O-194.003	Application
69O-194.005	Prepaid Health Clinic Contract
69O-194.009	Reporting Requirements
69O-194.010	Fees
69O-194.030	Forms Incorporated by Reference

69O-194.001 Scope.

~~The following rules govern the issuance of Certificates of Authority and the operation of prepaid health clinics pursuant to the provisions of part III, chapter 641, F.S., known as the "Prepaid Health Clinic Act."~~

Rulemaking Authority 641.403 FS. Law Implemented 641.403 FS. History—New 5-9-85, Formerly 4-69.01, 4-69.001, 4-194.001.

69O-194.002 Definitions.

(1) All terms defined in the Prepaid Health Clinic Act which are used in these rules shall have the same meaning as in the Act.

(2) PHC. Prepaid health clinics shall be abbreviated as PHC in these rules.

(3) Basic Services. Basic services include any of the following services which if offered shall meet the definitions in paragraphs (a) through (d) of this subsection:

(a) Emergency Care. Emergency outpatient services shall be provided on a twenty-four hour basis, either by the PHC through its own facilities or through guaranteed arrangements with other providers. Life-saving measures must be furnished. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times.

(b) Physician Care. Physician care including licensed paramedical and other ancillary health care personnel shall be of sufficient type and amount to provide adequately for the contracted services.

(c) Ambulatory Diagnostic Treatment. Ambulatory and/or outpatient diagnostic treatment services shall be provided with emphasis directed toward primary care.

(d) Preventive Health Care Services. A program of health evaluation, education and immunizations shall be provided which is designed to prevent illness and disease and to improve the general health of PHC subscribers. This program shall include at least the following:

1. Services for infertility;
 2. Well-child care from birth;
 3. Periodic health evaluations for adults;
 4. Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction;
- and;
5. Pediatric and adult immunizations, in accord with accepted medical practice.

(4) Assets.

(a) Assets Defined. In any determination of the financial condition of a ~~PHC prepaid health clinic~~, there shall be allowed as "assets" only those assets that are owned by the ~~PHC prepaid health clinic~~ and which assets consist of:

1. Cash in the possession of the PHC, or in transit under its control, including the true balance of any deposit in a solvent bank, savings and loan association, or trust company which is domiciled in the United States.

2. Investments, securities, properties, and loans acquired or held in accordance with part III, chapter 641, Florida Statutes, and in connection therewith the following items:

a. Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

b. Declared and unpaid dividends on stock and shares, unless the amount of the dividends has otherwise been

allowed as an asset.

c. Interest due or accrued upon a collateral loan which is not in default in an amount not to exceed 1 year's interest thereon.

d. Interest due or accrued on deposits or certificates of deposit in solvent banks, savings and loan associations, and trust companies domiciled in the United States, and interest due or accrued on other assets, if such interest is in the judgment of the ~~Office department~~ a collectible asset.

e. Interest due or accrued on current mortgage loans, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of 90 days be allowed as an asset.

f. Rent due or accrued on real property if such rent is not in arrears for more than 3 months, but in no event shall rent accrued for a period in excess of 90 days be allowed as an asset.

g. The unaccrued portion of taxes paid prior to the due date on real property.

3. Premiums in the course of collection, not more than 3 months past due, less commissions payable thereon. This ~~The foregoing~~ limitation shall not apply to premiums payable directly or indirectly by any governmental body in the United States or by any of their instrumentalities.

4. Furniture, fixtures, furnishings, vehicles, medical libraries, and equipment, if the original cost of each item is at least \$200, which cost shall be amortized in full over a period not to exceed 5 calendar years, unless otherwise approved by the ~~Office department~~.

5. Pharmaceutical and medical supply inventories.

6. The liquidation value of prepaid expenses.

7. Other assets, not inconsistent with the provisions of this rule, deemed by the ~~Office department~~ to be available for the payment of benefits and claims, at values to be determined by it.

(b) Evaluation of Assets. The Office, upon determining that a PHC's PHAGE's asset has not been evaluated according to applicable law or that it does not qualify as an asset, shall require the PHC to reevaluate the asset properly or to replace the asset with an asset acceptable to the Office within 90 days of this determination, if the removal of the asset from the PHC's PHAGE's assets would impair the PHC's PHAGE's solvency.

(c) Assets Not Allowed. In addition to assets impliedly excluded by the provisions of paragraph (a) of subsection (4), above, the following expressly shall not be allowed as assets in any determination of the financial condition of a PHC prepaid health clinic:

1. Good will, trade names, and other like intangible assets.

2. Advances to officers, directors, and controlling stockholders, whether secured or not, and advances to employees, agents, and other persons on personal security only.

3. Stock of the PHC owned by it directly, or owned indirectly by it through any entity in which the PHC owns or controls, directly or indirectly, more than 25 percent of the ownership interest ~~therein~~.

4. Leasehold improvements, nonmedical libraries, stationery, literature, and nonmedical supply inventories.

5. Furniture, fixtures, furnishings, vehicles, medical libraries, and equipment, other than those items authorized under subparagraph 5. of paragraph (a).

6. Notes or other evidences of indebtedness which are secured by mortgages or deeds of trust which are in default and beyond the express period specified in the instrument for curing the default.

7. Bonds in default for more than 60 days.

8. Deferred costs other than prepaid expenses.

(5) Liabilities.

(a) In any determination of the financial condition of a PHC prepaid health clinic, liabilities to be charged against its assets shall include:

1. The amount, estimated consistent with the provisions of part III, chapter 641, Florida Statutes, necessary to pay all of its unpaid losses and claims incurred for or on behalf of a subscriber on or prior to the end of the reporting period, whether reported or unreported.

2. The amount equal to the unearned portions of the gross premium charged on policies in force, computed in accordance with part III of chapter 641, Florida Statutes.

3. Taxes, expenses, and other obligations due or accrued at the date of the statement.

(b) Evaluation of liabilities. The Office, upon determining that a PHC has failed to report liabilities that should have been reported, shall require a corrected report which reflects the proper liabilities to be submitted by the PHC to the Office within 10 working days of receipt of notification.

(6) Security. Security means any note, stock, treasury stock, bond, debenture, evidence of indebtedness, certificate of interest or participation, whiskey warehouse receipt or other commodity warehouse receipt, or right to subscribe to any of the foregoing; certificate of interest in a profit-sharing agreement or the right to participate therein; certificate of interest in an oil, gas, petroleum, mineral, or mining title or lease, or the right to participate therein; collateral trust certificate, reorganization certificate, preorganization subscription, or any transferable share, investment contract, or beneficial interest in title to property, profits, or earnings; interests in or under a profit-sharing or participation agreement or scheme, or any other instrument commonly known as a security, including an interim or temporary bond, debenture, note, certificate, or receipt for a security or for subscription to a security.

(7) Surplus Notes. Surplus notes must meet the following requirements:

(a) They must be subordinated to the Florida minimum surplus requirement as provided for in section 641.407, Florida Statutes; ~~and~~

(b) They must be subordinated to all other liabilities; and,

(c) The PHC must obtain written consent from the Office before any repayment of principal or interest may be made.

(8) ~~Actuarially Sound. Means~~ ~~“Actuarially Sound” means~~ the ability of the proposed PHC to deliver all the services to be furnished by the PHC at the rate structure established including administrative costs, which shall be defined as general and administrative expenses for the PHC. Actuarial soundness will be determined by the department based on a review of the actuarial study under which the rates and loss reserves are established. Consideration will be given to the character and amount of guaranteed services by the organizers, the method of marketing, and the degree of market penetration that can reasonably be expected.

(9) Excessive, Inadequate or Unfairly Discriminatory Rates. A rate shall be deemed to be excessive if the rate is unreasonably high for the services provided when compared with the cost for similar health care services in the community. A rate shall be deemed to be inadequate if the continued use of the rate endangers the solvency of the PHC using it, or if continued use by the PHC has or will have the effect of being unfair competition or creating a monopoly. This provision is designed to promote efficient and effective operation of ~~PHC's PHAGE's~~. A rate shall be deemed to be unfairly discriminatory if the PHC knowingly makes or permits any unfair discrimination between individuals of the same actuarially supportable class and essentially the same hazard, in the amount of premium, policy fees, rates charged, or benefits payable under the terms or conditions of the contract, or in any other manner whatever.

(10) Premium. The fixed sum paid by or on behalf of a subscriber or group of subscribers on a prepaid per capita or prepaid aggregate basis for the services rendered by the PHC.

Rulemaking Authority 641.403 FS. Law Implemented 641.402(1), 641.405, 641.406, 641.418, 641.42, 641.441, ~~641.515~~ FS. History—New 5-9-85, Formerly 4-69.02, 4-69.002, 4-194.002.

69O-194.003 Prepaid Health Clinic Application.

Substantial rewording of Rule 69O-194.003, F.A.C. follows. See Florida Administrative Code for present text.

(1) An application for a person applying for a certificate of authority as a prepaid health clinic consists of the following:

(a) Form OIR-C1-483, “Application for Certificate of Authority Prepaid Health Clinic,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(b) Form OIR-C1-905, “Instructions for Furnishing Background Investigative Reports,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(c) Form OIR-C1-938, “Fingerprint Payment and Submission Procedures,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX; and

(d) Form OIR-C1-1423, “Biographical Affidavit,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX.

(2) A person applying for a certificate of authority as a prepaid health clinic shall submit forms in subsection (1) as directed by the Office electronically at <https://www.floir.com/iportal>.

(1) For the purposes of section 641.406, Florida Statutes, a “properly completed application” shall be one which:

(a) Meets all the requirements of section 641.405(2)(a) through (g), F.S.; and

(b) Meets the requirements of section 641.406, F.S.; and

(c) Meets the requirements of this rule chapter.

(2) For the purposes of section 13, chapter 84-313, Laws of Florida, a “complete and proper application” shall be one which:

(a) Meets all the requirements of section 641.405(2)(a) through (g), F.S., by May 1, 1985; and,

(b) Meets all the requirements of section 641.406, F.S., by November 1, 1985; and,

(c) Meets the requirements of this rule chapter.

(3) An application, on forms provided by the Office, accompanied by a filing fee of One Hundred Fifty Dollars (\$150.00) payable to “Chief Financial Officer, State of Florida” shall be completed by the responsible persons in each entity desiring to obtain a certificate of authority as a PHC. The application with copies in duplicate shall be attested and notarized and be accompanied by biographical information, financial statements and other supporting documents required by the application form. Applicants shall address correspondence to the PHC Section, Bureau of Allied Lines, Office of Insurance Regulation, Tallahassee, Florida 32301.

(4) A financial statement of the applicant, prepared on the basis of generally accepted accounting principles, shall be submitted with the application. If the applicant wishes to include surplus notes in its calculation of surplus, copies of those notes must be submitted to the department for prior approval.

(5) The applicant shall also submit a statement of its underwriting policies as part of the application.

(6)(a) Pursuant to the provisions of section 641.406, F.S., the Office shall issue a certificate of authority for a PHC within 60 days after the PHC has:

1. Filed a properly completed application; and,

2. Paid the prescribed fees; and,

3. Satisfied the Office regarding the requirements set out in section 641.406, Florida Statutes.

(b) The provisions of paragraph 69O-31.003(5)(a), F.A.C., notwithstanding, if a hearing pursuant to chapter 120, F.S., is requested and held prior to the issuance of a certificate of authority, the Office shall issue a certificate of authority for a PHC within 60 days after the final order has been entered, if the PHC prevails.

Rulemaking Authority 641.403 FS. Law Implemented 641.405, 641.406 FS. History—New 5-9-85, Formerly 4-69.03, 4-69.003, 4-194.003.

69O-194.005 Prepaid Health Clinic Contract.

(1)(a) “Prepaid health clinic” or “PHC contract” means the certificate or contract provided to the subscriber which describes the health care services provided and the amount to be charged. Every subscriber shall be given a PHC contract unless subsection (2) of this rule applies.

(b) Both individual and family prepaid health clinic contracts must contain the entire agreement between the PHC and the subscriber, including ~~but not limited to:~~ date of contract; rate to be charged; mode of payment, which shall be monthly; grace period for late payment; copayment features, if any; renewal conditions; services to be furnished; names and addresses of the clinics or other facilities at which services are available; provisions pertaining to pre-existing conditions; limitations; exclusions and exceptions, such as waiting periods, specific conditions not covered and limitations on length of stay, enrollment and disenrollment procedures, and all other qualifying or limiting features; provisions pertaining to amount and kind of reimbursement made if the illness or accident happens outside of the PHC’s ~~PHAGE’s~~ geographic area and an explanation of this coverage; provisions for adding new family members; and any other information necessary for a complete understanding of what is covered and what is excluded by the contract.

(2) Group master prepaid health clinic contracts must also contain complete information as described above, but a certificate may be issued to the subscriber showing the salient features of the plan along with a descriptive pamphlet or brochure to explain the coverage fully.

(3) Provisions relating to grievances must be included in all prepaid health clinic contracts and certificates.

(4) All prepaid health clinic contracts must be clear and legible. All limitations, exclusions, and exceptions must

be grouped together with captions in bold-faced type and shall be printed with at least the same prominence as provisions which describe the benefits.

Rulemaking Authority 641.403 FS. Law Implemented 641.42, 641.405, 641.406, 641.408, 641.421 FS. History—New 5-9-85, Formerly 4-69.05, 4-69.005, 4-194.005.

69O-194.009 Reporting Requirements.

Substantial rewording of Rule 69O-194.009, F.A.C. follows. See Florida Administrative Code for present text.

(1) Each PHC shall file with the Office a full and true report of its financial condition, transactions, and affairs.

(a) An annual report covering the preceding fiscal year shall be filed on or before April 1 or within 3 months of the end of the reporting period of the clinic.

1. The executed Jurat page of said report shall be transmitted electronically to the Office via the Regulatory Electronic Filing System, “REFS.” The date affixed by the Office’s electronic data processing system shall serve as evidence of the timeliness of the report. A report in any other format shall not be submitted to the Office.

2. Each PHC shall submit its report electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions incorporated by reference in paragraph 69O-137.001(3)(b), F.A.C.

3. The report shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(a), F.A.C.

4. Copies of the manuals are available:

a. From the National Association of Insurance Commissioners at <http://www.naic.org> and

b. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.

(b) Form OIR-A2-949, “Annual Report Contracts Issued & Outstanding,” effective 12/20, hereby incorporated by reference and available www.flrules.org/XXXXX. Form OIR-A2-949 shall be submitted electronically on or before April 1 or within 3 months of the end of the reporting period of the clinic via the Office’s system at <https://www.floir.com/iportal>.

(c) Form OIR-A2-950, “Annual Report Damage Claims & Medical Injury,” effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX. Form OIR-A2-950 shall be submitted electronically on or before April 1 or within 3 months of the end of the reporting period of the clinic via the Office’s system at <https://www.floir.com/iportal>.

(2) The Office shall grant an extension of time to file an annual report in subsection (1) if there exist conditions beyond the control of the authorized PHC, such as rehabilitation pursuant to section 641.419, F.S., or the laws of the state of domicile; severe damage to the PHC’s physical premises by a natural or man-made disaster; or some other reason of similar gravity and severity. The request for an extension of time for filing an annual report shall be submitted to the Office at least 10 days before the filing is due. The extension shall be for the amount of time reasonable to file under the conditions which justified the extension.

~~(1) Each PHC shall furnish to the Office, with a copy to the Department of Health, a report annually, as prescribed by law.~~

~~(2) The annual report shall meet the requirements of section 641.41, F.S., and shall include:~~

~~(a) The completed annual report form prescribed by the Office.~~

~~(b) An audited financial statement prepared by a certified public accountant covering the reporting period.~~

~~(c) A projected balance sheet for the end of the next reporting period.~~

~~(d) A projected monthly operating statement for the next reporting period.~~

~~(e) A projected monthly cash budget covering the next reporting period.~~

~~(f) Full justification that the rates are actuarially sound for the benefits provided and that the loss reserves for unpaid claims are adequate.~~

~~(g) A current list of all providers or provider groups under contract to the PHC (including physicians, group practices, specialists, and ancillary providers) stating the name, specialty and address of each provider or provider group. The PHC shall also provide a sample of each provider contract used.~~

~~(h) A list of all subscriber contracts currently in use (listed by form number) with the rates for each contract.~~

~~(3) Other reporting requirements. To determine compliance with part III, chapter 641, F.S., the following reports are required:~~

(a) Quarterly Reports. These reports are due within 45 days of the end of each calendar quarter. The report shall include:

1. The completed report form prescribed by the Office; and,
2. A current list of all providers under contract to the PHC, including their names, addresses, and specialties.

(b) Monthly Marketing Statistical Report. This report is due before the 15th day of each month. The report consists of the completed form prescribed by the Office for the immediately preceding month's marketing statistics.

(c) Such other reports as may be required relating to the performance of PHAGE's.

Rulemaking Authority 641.403, 641.41(1) FS. Law Implemented 641.41 FS. History—New 5-9-85, Formerly 4-69.09, 4-69.009, 4-194.009.

690-194.010 Fees.

Checks for the original filing or amendments thereto, and for filing of each annual report shall be made payable to the "Chief Financial Officer, State of Florida." ~~The portion allotted to the Department of Health shall then be remitted to that Department by the Chief Financial Officer.~~

Rulemaking Authority 641.403 FS. Law Implemented 641.412 FS. History—New 5-9-85, Formerly 4-69.10, 4-69.010, 4-194.010.

690-194.030 Forms Incorporated by Reference.

The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 641, Part III, F.S.:

Title	Form Number
(1) Application for Certificate of Authority Prepaid Health Clinic Certificate	OIR C1 483 http://www.flrules.org/Gateway/reference.asp?No=Ref 08305 (Rev 5/17)
(2) Annual Reports	OIR A2 949 http://www.flrules.org/Gateway/reference.asp?No=Ref 08278 (07-04) and OIR A2 950 http://www.flrules.org/Gateway/reference.asp?No=Ref 08279 (07-04)
(3) Authority for Release of Information	OIR C1 450 http://www.flrules.org/Gateway/reference.asp?No=Ref 08301 (5/00)
(4) Biographical Affidavit	OIR C1 1423 http://www.flrules.org/Gateway/reference.asp?No=Ref 08283 (8/14)
(5) Abbreviated Biographical Statement	OIR 449 (5/89)
(6) Service of Process Consent & Agreement	OIR C1 144 http://www.flrules.org/Gateway/reference.asp?No=Ref 08280 (06/2004)
(7) Statement of Acquisition, Merger or Consolidation of a Specialty Insurer Pursuant to Sections 628.461, 628.4615, F.S.	OIR C1 448 http://www.flrules.org/Gateway/reference.asp?No=Ref 08281 (12/05)
(8) Fingerprint Payment and Submission Procedure	OIR C1 938 http://www.flrules.org/Gateway/reference.asp?No=Ref 08296 (5/2013)
(9) Instructions for Investigative Report	OIR C1 905 http://www.flrules.org/Gateway/reference.asp?No=Ref 08302 (2/15)

Copies of the forms may be obtained from the Office of Insurance Regulation's website:
<http://www.flor.com/iportal>.

*Rulemaking Authority 641.403 FS. Law Implemented 624.424, 624.501(26), 641.402, 641.405, 641.41, 641.416 FS.
History—New 6-25-90, Formerly 4-69.081, 4-194.030, Amended 7-30-17.*



Florida Office of Insurance Regulation

**ANNUAL REPORT
CONTRACTS ISSUED
& OUTSTANDING**

**MANAGED
CARE
COMPANY:** _____

YEAR ENDING: _____

**Number of health contracts issued and outstanding and number terminated.
[HMOs-641.26(1)(d), F.S.; PHCs-641.41(1)(c), F.S.; PLHSOs-636.043(2)(c), F.S.]**

Group subscriber contracts issued and outstanding

Individual subscriber contracts issued and outstanding

Group subscriber contracts terminated

Individual subscriber contracts terminated



Florida Office of Insurance Regulation

ANNUAL REPORT

**DAMAGE CLAIMS &
MEDICAL INJURY**

**MANAGED
CARE
COMPANY:** _____

YEAR ENDING: _____

**The number and amount of damage claims for medical injury initiated against the health entity and any providers engaged by it during the reporting year.
[HMOs-641.26(1)(e), F.S.; PHCs-641.41(1)(e); PLHSOs 636.043(2)(d)]**

Number of Claims

Total Dollar Value of Claims

Number of Claims Without Legal Process

Number of Claims Disposed (Settled, or Otherwise Discharged)



Office of Insurance Regulation
Company Admissions

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID HEALTH CLINIC

This package is designed to assist individuals in preparing the application with all the information required by statute and to facilitate expeditious processing of the application by this Office.

PLEASE NOTE: THE COMPLETED CHECK LIST MUST BE SUBMITTED WITH THE APPLICATION PACKAGE.

The completed application package must be submitted to the Office by utilizing the following link:

<http://www.floir.com/iportal>
and select iApply – Online Company Admissions

If this package requires submission of forms and/or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <http://www.floir.com/iportal> and select "Form & Rate Filing Assembly and Submission" to begin the submission of forms and/or rates.

If this package requires original documents, in lieu of providing original paper documents, the Applicant is directed to submit a PDF of the original document(s) unless otherwise required by Florida Statutes.

Any questions concerning this application package or iApply may be directed to lhappcoord@floir.com.

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID HEALTH CLINIC**

Statutory Authority

S. 641.405(1)

Pursuant to Chapter 641, Part III, Florida Statutes, application is hereby made to operate a Prepaid Health Clinic.

Proposed name of Prepaid Health Clinic:

Name: _____

Address: _____

Phone: _____

FEIN: _____

How long has the PHC been in operation:
(Specify beginning date): _____

Please be specific in your answers and provide supporting documentation for each item. The items are as follows:

ORGANIZATIONAL

Statutory Authority

- _ 1. S. 641.405(2)(f) Enclose a copy of the Health Care Provider Certificate, as issued by the Agency for Health Care Administration or evidence that application has been made for a Health Care Provider Certificate.
- _ 2. S. 641.412(1)(a) A check for \$150 made payable to "Department of Financial Services" covering the filing fee for this application.
- _ 3. S. 641.405(2)(a) A copy of the PHC's basic organizational documents including Articles of Incorporation, Articles of Association, Partnership Agreement(s), Trust Agreement, or other applicable documents and all amendments thereto.
- _ 4. S. 641.405(2)(a) If the proposed PHC is already incorporated, a copy of the Certificate of Incorporation as filed with the Secretary of State.
- _ 5. S. 641.405(2)(b) A copy of the proposed PHC's Bylaws, Rules or Regulations, or similar form of document.
- _ 6. S. 641.405(2)(c) A list of names, addresses, and official capacities of all persons who are to be responsible for the conduct of the PHC's affairs including officers and directors, trustees, partners, and associates.
- _ 7. S. 641.406(7) A list of the owners of the PHC, including the number of shares of stock or ownership interest of each person.
- _ 8. S. 641.406(7) Complete biographical information, to be submitted on forms provided in this application packet, on all persons controlling 10% or more of the ownership interest of the PHC, and all officers, directors, trustees, partners, or associates of the Prepaid Health Clinic.

Statutory Authority

The requirements for the affiant's social security number (SSN) as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the Biographical Affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also, please mark CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

- _ 9. S. 641.405(2)(c) Copies of all contracts, past or current, between the PHC and any person listed in item "6", or with any entity of which any of these persons is an officer, director, partner, trustee, or associate, in which he or any member of his family owns 10% or more of stock or other financial interest including any possible conflicts of interest.

- _ 10. S. 641.406(7) Documentary evidence that the governing body of the PHC has designated a qualified administrator to manage the PHC's operations. This should include a resume of the administrator.

Statutory Authority

CONTRACTUAL

- _ 11. S. 641.405(2)(e) One copy of every contract, rider, endorsement, certificate, application, or other form the PHC proposes to offer to its subscribers. Follow the list of requirements for individual and group contracts enclosed in this application kit, as well as the requirements in the law concerning the definition of basic services and for PHC contracts. Every subscriber contract must be identified by a unique form number located on the lower left corner of each page of the contract.
- _ 12. S. 641.427 A list of the reasons for which the PHC can terminate a subscriber's contract and the reasons for which the subscriber can terminate his or her contract.
- _ 13. S. 641.405(2)(e) A table of rates proposed to be charged for each form of subscriber contract.
- _ 14. S. 641.42(5) A complete description of the procedure established for handling subscriber grievances.

MARKETING

- _ 15. S. 641.405(2)(d) A statement generally describing the clinic and its operations.
- _ 16. S. 641.441 A copy of all advertising to be used or currently in use. This includes print advertising and scripts for TV or radio advertising.
- _ 17. S. 641.406(4) A complete explanation of the manner in which the PHC will merchandise subscriber contracts.
- _ 18. S. 641.405(2)(c) A list of the names and addresses of all sales representatives.
- _ 19. S. 641.405(2)(e) A statement giving the present (if applicable) projected number of subscribers to be enrolled yearly for the next three years.

FINANCIAL

Statutory Authority

____ 20.	S. 641.406(6)	Executed copies of the insurance policies covering general liability and medical malpractice insurance for the PHC.
____ 21.	S. 641.406(6)	An executed copy of the PHC's fidelity bond covering employee dishonesty.
____ 22.	S. 641.406(6)	If the PHC has secured catastrophic or back-up insurance coverage (reinsurance for the excess loss coverage), you are required to submit executed copies of the policy or policies.
____ 23.	S. 641.405(2)(g)	A current financial statement, including all assets and liabilities of the PHC, also contingent liabilities, unpaid obligations, and actions or suits pending against or anticipated, prepared on the basis of generally accepted accounting principles.
____ 24.	S. 641.407	A statement of the proposed initial working capital reserves of the PHC.
____ 25.	S. 641.405(2)(g)	If your group is already operating as a clinic, a profit and loss statement and balance sheet for the past three years.
____ 26.	S. 641.405(2)(g)	If your group has not been operating as a PHC, a pro-forma (projected) operating statement for the first year and a projected balance sheet (statement of financial position) at the end of the first year.
____ 27.	S. 641.406(3)	The method in which the PHC shall comply with the minimum surplus requirement of Section 641.407, Florida Statutes.
____ 28.	S. 641.405(2)(g)	A cash flow analysis of the PHC for the period until the PHC shows three months of profitability. (If the PHC is already profitable, provide one year analysis).
____ 29.	S. 641.409(1)(a) S. 641.409(1)(b) S. 641.409(3)	The method in which the PHC shall comply with the minimum surplus requirement of Section 641.409, Florida Statutes. All PHCs must make a deposit with the Office of Insurance Regulation in the amount of \$30,000. Also, PHCs must purchase insurance or a surety bond in the amount acceptable to the Office, which shall cover the subscribers in the event of insolvency of the PHC.

Statutory Authority

- _ 30. S. 641.406(2) An actuarial analysis of the rates of the PHC, showing that the proposed rates are actuarially sound for the benefits provided, including administrative costs.
- _ 31. S. 641.405(2)(c) Copies of all relevant business leases.
- _ 32. S. 641.43 Written contracts identifying each physician or physician group that will be providing service to PHC subscribers. Such contracts must include the hold-harmless clause for subscribers which is required by Section 641.43, Florida Statutes.

This application must be signed by two officers of the PHC and notarized by a notary public.

Signed this _____ day of _____, 20_____.

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 2020, by _____
(name of person)

as _____ for _____
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
PREPAID HEALTH CLINIC**

Company Name

Address

City, State, Zip

(Fee 641.412, Florida Statutes)

Application	\$100.00	12-43	3092
Filing Fee	\$ 50.00	12-43	2062
Annual Report	\$100.00	12-44	3091
Filing Fee	\$ 50.00	12-44	2062

Please mail fees to:

Department of Financial Services
Revenue Processing Section
Post Office Box 6100
Tallahassee, Florida 32314-6100

All other correspondence and requests should be sent to:

Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Room 316.16
Tallahassee, Florida 32399-0332



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail **ONLY** completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

2. a. Are you a citizen of the United States?

Yes ☐ No ☐

b. Are you a citizen of any other country?

Yes ☐ No ☐

If yes, what country? _____

3. Affiant's occupation or profession: _____

4. Affiant's business address: _____

Business telephone: _____ Business Email: _____

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Present or proposed position with the Applicant Company: _____

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐ No ☐

If any claims were made on the bond, give details: _____

- b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐ No ☐

If yes, give details: _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

- a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes ☐ No ☐

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

- b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
- Yes ☐ No ☐
- c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
- Yes ☐ No ☐
- d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
- Yes ☐ No ☐
- h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
- Yes ☐ No ☐
- i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
- Yes ☐ No ☐
- j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
- Yes ☐ No ☐

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person,

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details. _____

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☐

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details: _____

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☐

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☐

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Yes ☐ No ☐

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

**BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information**

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____

IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☐

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

4. Government Identification Number if not a U.S. Citizen: _____

5. Foreign Student ID# (if applicable) : _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. Date of Birth: (MM/DD/YY) : _____ Place of Birth, City: _____
State/Province: _____ Country: _____

7. Name of Affiant's Spouse (if applicable) : _____

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

___ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[name of CRA, address]** (“CRA”). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency (“CRA”) by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.” You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

CHAPTER 690-200
MOTOR VEHICLE SERVICE AGREEMENT COMPANIES

690-200.001 Purpose and Scope.

Rulemaking Authority 634.021 FS. Law Implemented 624.307(1), 634, Part I FS. History—New 6-25-90, Formerly 4-114.001, 4-200.001, Repealed.

690-200.002 Definitions.

Rulemaking Authority 634.021 FS. Law Implemented 634.011 FS. History—New 5-26-93, Formerly 4-200.002, Repealed.

690-200.004 Application for License and License Renewal. ~~Qualification to Obtain and Hold a License.~~

Substantial rewording of Rule 690-200.004, F.A.C. follows. See Florida Administrative Code for present text.

(1) Application for License as a Motor Vehicle Service Agreement Company

(a) An application for a license as a motor vehicle service agreement company consists of the following:

1. Form OIR-C1-994, “Application for License Motor Vehicle Service Agreement Company,” effective 3/21, hereby incorporated by reference and available at www.flrules.org/XXXXX;

2. Form OIR-C1-144, “Service of Process Consent & Agreement,” effective 6/04, hereby incorporated by reference and available at www.flrules.org/XXXXX;

3. Form OIR-C1-905, “Instructions for Furnishing Background Investigative Reports,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

4. Form OIR-C1-938, “Fingerprint Payment and Submission Procedures,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

5. Form OIR-C1-995, “List of Proposed Sales Representatives,” effective 10/05, hereby incorporated by reference and available at www.flrules.org/XXXXX;

6. Form OIR-C1-1423, “Biographical Affidavit,” effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX; and

7. Form OIR-C1-2221, “Management Information Form,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(b) A person applying for a license as a motor vehicle service agreement company shall submit the forms listed in paragraph (1)(a) as directed by the Office electronically at <https://www.flair.com/iportal>.

(2) License Continuance for Motor Vehicle Service Agreement Company

(a)1. All motor vehicle service agreement company licenses shall continue in force as long as licensee is entitled thereto under chapter 634, Part I, Florida Statutes.

2. Failure to submit the application for continuance by March 1 shall result in expiration of the license and will require the filing of a new application for licensure.

(b) A licensee seeking to continue operating as a motor vehicle service agreement company shall submit Form OIR-A3-467 LR, “Application for License Continuance Motor Vehicle Service Agreement Company,” effective 5/21, hereby incorporated by reference and available at www.flrules.org/XXXXX, filed electronically at <https://www.flair.com/iportal>.

Rulemaking Authority 634.021, 634.061(1), (2)(c) FS. Law Implemented 634.041 FS. History—New 5-26-93, Formerly 4-200.004, Amended 8-13-12, .

690-200.006 Contractual Liability Insurers.

Rulemaking Authority 634.021 FS. Law Implemented 634.041 FS. History—New 5-26-93, Formerly 4-200.006, Amended 8-13-12, Repealed.

690-200.009 Form Requirements ~~Filings~~.

(1) No change.

(2) Every service agreement issued in this state shall contain at least the following:

- (a) through (b) No change.
- (c) A space for identifying the ~~salesperson~~ ~~salesman~~ licensed under section 634.171, F.S.;
- (d) A space for a ~~an~~ unique identifying number;
- (e) A space for an issue and expiration date; and,
- (f) No change.

Rulemaking Authority 634.021 FS. Law Implemented 634.121 FS. History—New 5-26-93, Formerly 4-200.009, Repromulgated 8-13-12. Amended _____.

69O-200.011 ~~Noncompliant Disapproval of Forms.~~

A company may be ordered to stop using any form will be disapproved if:

- (1) It does not meet the minimum requirements set forth in rule 69O-200.009, F.A.C.; ~~or and/or~~
- (2) Contains names, telephone numbers, or other language which makes it difficult for the service agreement-buying public to determine which company actually has issued and is liable for the service agreement. This may include, ~~but is not limited to,~~ the following:
 - (a) Prominent use of trade names; and,
 - (b) No change.

Rulemaking Authority 634.021 FS. Law Implemented 634.1213 FS. History—New 5-26-93, Formerly 4-200.011, Amended _____.

69O-200.014 Exemption Financial Examination.

Rulemaking Authority 634.021 FS. Law Implemented 634.141, 634.416 FS. History—New 5-26-93, Formerly 4-200.014, Amended 8-13-12, Repealed _____.

69O-200.015 Forms Incorporated by Reference.

Rulemaking Authority 634.021 FS. Law Implemented 634.041, 634.061, 634.071, 624.501, 634.161, 634.252 FS. History—New 6-25-90, Formerly 4-114.015, Amended 5-26-93, 6-6-94, Formerly 4-200.015, Amended 8-13-12, Repealed _____.

69O-200.017 Annual Reports.

Annual Reports are to be filed with the Office, on or before March 1 of each year, on Form OIR-A3-467, “Annual Report for Motor Vehicle Service Agreement Company,” effective 5/21, hereby incorporated by reference and available at www.flrules.org/XXXXX, and Form OIR-A3-1984, “Annual Report for Motor Vehicle Manufacturers,” effective 5/21, hereby incorporated by reference and available at www.flrules.org/XXXXX. The filings shall be submitted electronically at <https://www.flair.com/iportal>. If the Annual Report is not completed to include all information requested in the format provided, then it will not be deemed filed until all deficiencies are corrected.

Rulemaking Authority 634.021, 634.137(1), (5) FS. Law Implemented 634.137 FS. History—New _____.



Office of Insurance Regulation

Licensee: _____
Address: _____
City, State Zip _____

APPLICATION for LICENSE
CONTINUANCE

MOTOR VEHICLE SERVICE
AGREEMENT COMPANY

For the period: 03/01/20 __ __ to 02/2 __/20 __ __

Federal Employer ID Number: __ __ - __ __ __ __ __ __

FL Company Code: __ __ __ __

Due by March 1

IN COMPLIANCE WITH THE LAWS OF FLORIDA, THE ABOVE NAMED DOES HEREBY APPLY FOR RENEWAL OF ITS MOTOR VEHICLE SERVICE AGREEMENT COMPANY LICENSE AUTHORIZING THE AFORESAID TO PERFORM SUCH DUTIES IN THIS STATE PURSUANT TO THE LAWS OF FLORIDA.

President's Name

Signature

Date

Secretary's Name

Signature

Date

Treasurer's Name

Signature

Date

INSTRUCTIONS:

1. If you wish to renew, complete and sign this application, detach it from this report and forward it along with your remittance in the amount of \$100.00 made payable to the **Florida Department of Financial Services**.
2. The application and remittance must be sent to:

Florida Department of Financial Services
Revenue Processing Section
Post Office Box 6100
Tallahassee, Florida 32314-6100

3. The renewal application and remittance must be received on or before March 1.

AMOUNT	TYPE	CLASS	FEE	TR ACCT
\$100.00	10	33	L	3002

Office of Insurance Regulation

FLORIDA COMPANY
CODE:

FEDERAL EMPLOYER
IDENTIFICATION NUMBER:

**ANNUAL REPORT
FOR MOTOR
VEHICLE SERVICE
AGREEMENT COMPANY
OF THE**

(Motor Vehicle Service Agreement)

**TO THE
OFFICE OF INSURANCE REGULATION
OF THE
STATE OF FLORIDA**

Specialty Product Administration
200 East Gaines Street
Tallahassee, FL 32399 - 0331

FOR CALENDAR YEAR ENDED

**DUE ON OR BEFORE
MARCH 1 EACH YEAR**

GENERAL INFORMATION AND INSTRUCTIONS

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
2. The Balance Sheet, Statement of Operations and the Statement of Cash flows must be prepared based on year-end amounts.
3. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
4. This form is submitted electronically. Adobe Reader version 7.0.5 or higher is required. If you do not have that version, please upgrade at <http://www.adobe.com> prior to downloading any forms.
5. When you downloaded this report, you were assigned a session key. This session key has an expiration date that was also assigned prior to downloading this form. **Please make sure you save or submit prior to this expiration date or all work up until the last save will be lost.**

This session will expire on:

Eastern Time

6. To assist you in completing this form click both "Highlight Fields" and "Highlight Required Fields" in the upper right hand corner of the report page. This will highlight the fields where you may enter data.
7. The report form will calculate all totals and pre-populate fields based upon your responses. Data cannot be entered into the total and pre-populated fields.
8. Please enter all numeric fields with numbers only (no commas, dashes, dollar signs, etc.). Unanswered questions and blank lines on schedules will not be accepted. If no answers or entries are to be made, enter "0" on all lines asking for a numeric response and "None" or "N/A" on all lines requesting a non-numeric response. Additionally, certain Schedules and Exhibits provide the option "Check if N/A" if the information requested is not applicable to your company.
9. Line descriptions may not be altered or added. When in doubt where to place an item, show the item in an appropriate "Other" line and include a supplemental schedule describing the items listed in the "Other" category. Any item which is of an extraordinary nature should also be entered on an appropriate "Other" line.
10. "Save" or "Submit" buttons are provided on the last page of this report. Hit the ALT+s keys to go to the last page. By clicking the Save button, all data entered on the form will be saved to our website. **It is strongly recommended that you save your data periodically as you fill in this form.** You will receive a confirmation message once the data is successfully saved.
11. When you either save or submit the form, all data is checked for completeness; you will be notified if errors have occurred. When submitting data, you will be asked to correct these validation errors. Once the form is successfully submitted, the form becomes read-only. **To update information after submission, an amended form must be filed through REFS.**
12. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the item being answered. This additional information should be in electronic format (i.e. Word, Excel, PDF, etc) or, if in paper format, scanned in as a PDF, and should be attached and uploaded to the filing as a Miscellaneous Document through REFS.
13. When you have completed a form and selected "Submit Final," your report form is uploaded as a "Completed" document to your Component List; this does not submit the report to the Office of Insurance Regulation. Upon completion of all required items, the "Begin Submission Process" button (bottom right of the screen) will activate. You must select and complete the "Begin Submission Process" to successfully submit your entire filing to OIR.
14. Please print, sign, notarize and upload a PDF version of the Jurat/Attestation Page (see next page) under the corresponding component in REFS. If you do not have a component so named, please upload a signed PDF under the Miscellaneous Documents component.

STATEMENT

Please see the Instructions Page OR you may notarize this form electronically by entering the Notary Public, Commission Number and Expiration Date on the form prior to submitting.

Company Name: _____

Company FEIN: _____Florida Company Code: _____Period Ending Date: _____

State and Date of Incorporation/Organization: _____(State/Prov): _____(Date): _____

Date Licensed by the Office of Insurance Regulation: _____(Date): _____

Date Commenced Business: _____(Date): _____

Address of Home Office:

Street: _____

City: _____State/Prov: _____Zip/Postal Code: _____

Phone: _____Ext: _____Fax: _____

Address of Main Administrative Office:

Street: _____

City: _____State/Prov: _____Zip/Postal Code: _____

Phone: _____Ext: _____Fax: _____

Mailing Address:

Street: _____

City: _____State/Prov: _____Zip/Postal Code: _____

Phone: _____Ext: _____Fax: _____

Records Location (if different than Main Office):

Street: _____

City: _____State/Prov: _____Zip/Postal Code: _____

Address of Principle Florida Office:

Street: _____

City: _____State/Prov: _____Zip/Postal Code: _____

Phone: _____Ext: _____Fax: _____

Website: _____

Type of entity (check one)

☐ Corporation - For profit

☐ Sole proprietorship

☐ Corporation - Not for profit

☐ Limited liability company

☐ Partnership

☐ Other: _____

Contact Name: _____

Contact Title: _____

Phone: _____Ext: _____Fax: _____

Email Address: _____

OFFICERS / DIRECTORS / MEMBERS
Show full name (initials not acceptable)

Chief Executive Officer

President

Vice President

Secretary

Treasurer / Chief Financial Officer

Chairman of the Board

Directors / Members

STATE OF: _____

COUNTY OF: _____

_____, President, _____, Secretary,

and _____, Chief Financial Officer (or corresponding person having charge of the

financial records of the licensee), of the _____ being duly sworn

each for himself or herself deposes and says that they are the above-described officers of the said licensee, and that on the reporting

period stated above, all of the herein assets were the absolute property of the said licensee, free and clear from any liens or claims

thereon, except as herein stated, and that this report, together with related exhibits, schedules and explanations therein contained,

annexed or referred to is a full and true statement of all assets and liabilities and of the condition and affairs of the said licensee as of

the reporting period stated above, and of its income and deductions for the period reported.

The foregoing instrument was acknowledged before me by _____ President/Owner

means of ☐ physical presence or ☐ online notarization, _____

_____ day of _____, 20 _____ Secretary

Notary Public: _____ Treasurer/CFO

Commission Number: _____

Expiration Date: _____

Print this page

BALANCE SHEET
ASSETS

	December 31	
CURRENT ASSETS:	Current Year	Last Year
1. Cash on Hand and on Deposit (Schedule A - Page 7)		
2. Investments (Schedule B - Page 8)		
3. Receivables (Schedule C - Page 9)		
Allowance for Doubtful Accounts	()	()
4. Prepaid Expenses		
5. Inventories		
6. Other Current Assets (Schedule D - Page 10)		
7. Total Current Assets		
NON-CURRENT ASSETS:		
8. Investments (Schedule B - Page 8)		
9. Receivables (Schedule C - Page 9)		
Allowance for Doubtful Accounts	()	()
10. Deferred Acquisition Expenses (Attach Details)		
11. Deferred Expenses		
12. Intangible Assets		
13. Other Non-Current Assets (Schedule D - Page 10)		
14. Total Non-Current Assets		
FIXED ASSETS (NET OF ACCUMULATED DEPRECIATION)		
15. Real Estate Owned		
16. Automobiles		
17. Office Equipment & Furniture		
18. Leasehold Improvements		
19. Other Fixed Assets (Schedule D - Page 10)		
20. Total Fixed Assets (Net of Accumulated Depreciation)		
21. Total Assets		
22. Less Non-Admitted Assets (Schedule E, Line 10, Page 11)	()	()
23. TOTAL ADMITTED ASSETS		

BALANCE SHEET
LIABILITIES AND STOCKHOLDERS' EQUITY

		December 31	
LIABILITIES:		Current Year	Last Year
1.	Accounts Payable		
2.	Commissions Payable		
3.	Taxes Payable		
4.	Current Portion of Notes Payable (Schedule F - Page 12)		
5.	Accrued Interest Payable		
6.	Claims Payable / Reserve		
a.	Motor Vehicle Warranty (F.S. 634, Part I)		
b.	Home Warranty (F.S. 634, Part II)		
c.	Service Warranty (F.S. 634, Part III)		
7.	Other Current Liabilities (Schedule G - Page 14)		
8.	Total Current Liabilities		
9.	Reserve for Unearned Premium		
a.	Motor Vehicle Warranty (F.S. 634, Part I)		
b.	Home Warranty (F.S. 634, Part II)		
c.	Service Warranty (F.S. 634, Part III)		
10.	Long Term Portion of Notes Payable (Schedule F - Page 12)		
11.	Other Long Term Liabilities (Schedule G - Page 13)		
12.	Total Long Term Liabilities		
13.	Total Liabilities		
STOCKHOLDERS' EQUITY:			
14.	Common Stock		
15.	Preferred Stock		
16.	Additional Paid-in Capital		
17.	Retained Earnings (Line 17 - Page 6)		
18.	Less Treasury Stock	()	()
19.	Other (Attach Detail)		
20.	Total Stockholders' Equity		
21.	TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY		
22.	Total Stockholders' Equity (Line 20 above)		
23.	Less Non-Admitted Assets (Schedule E, Line 10, Page 11)	()	()
24.	Statutory Net Worth		

STATEMENT OF OPERATIONS AND RETAINED EARNINGS

	December 31	
INCOME:	Current Year	Last Year
1. Premiums Earned		
a. Motor Vehicle Warranty (F.S. 634, Part I)		
b. Home Warranty (F.S. 634, Part II)		
c. Service Warranty (F.S. 634, Part III)		
2. Total Net Investment Income Earned:		
a. Net Income Earned on all Reserves		
b. Net Income Earned on Other Investments		
3. Net Realized Capital Gains (or Losses)		
4. Other Income (Attach Schedule)		
5. Total Income		
EXPENSES:		
6. Claims		
a. Motor Vehicle Warranty (F.S. 634, Part I)		
b. Home Warranty (F.S. 634, Part II)		
c. Service Warranty (F.S. 634, Part III)		
7. Commissions to Agents		
8. General Expenses (Attach Schedule)		
9. Total Expenses		
10. Net Gain (or Loss) from operations before Federal and State Income Taxes and Extraordinary Item(s)		
11. Extraordinary Item(s) (Attach Schedule)		
12. Federal and State Income Taxes		
13. Net Gain (or Loss) from Operations		
14. Retained Earnings, December 31, Previous Year		
15. Other (Attach Details)		
16. Less Dividends to Stockholders	()	()
17. RETAINED EARNINGS (Enter on Line 17, Page 5)		

Year Ending:

☐ Check if Not Applicable[illegible]

Month	Balance	Month	Balance	Month	Balance	Month	Balance
JAN		APR		JUL		OCT	
FEB		MAY		AUG		NOV	
MAR		JUN		SEP		DEC	

Year Ending:

Place a check in the column marked with an asterisk (*) if this investment represents reserve funds invested. Show all stocks, bonds, debenture bonds, collateral or mortgage notes owned and list in the order of their maturity. If stocks and bonds are not traded on one of the major exchanges or over-the-counter, then sufficient information should be given so that the investments may be verified. Collateral and mortgage notes owned should also reflect sufficient data for confirmation. If investment is on deposit with the Department, indicate with a check in the column marked with a number sign (#).

Description	Maturity Date or Number of Shares	*	#	Market Value	Original Cost
Current:	☐ Check if Not Applicable				
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
	Total Current (Line 2, Page 4):				
Non-Current:	☐ Check if Not Applicable				
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
	Total Non-Current (Line 8, Page 4):				
	TOTAL INVESTMENTS:				

Company Name:

Year Ending:

SCHEDULE C
RECEIVABLES

Place a check in the column marked with an asterisk (*) on all receivables which are past due over 90 days. Under **Description / Name of Debtor**, identify if the Debtor is an **Affiliate**, **Director**, **Officer**, **Shareholder**, or **Employee / Salesperson**.

Description / Name of Debtor	*	Security / Nature of Debt	Balance
Current:	☐ Check if Not Applicable		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
		Total Current (Line 3, Page 4):	
Non-Current:	☐ Check if Not Applicable		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
		Total Non-Current (Line 9, Page 4):	
		TOTAL RECEIVABLES:	

SCHEDULE D
OTHER ASSETS
(Net of Accumulated Depreciation)

Identify as current, non-current, or fixed where appropriate. Place a check in the column marked with an asterisk (*) if all or any part of the asset is assigned as collateral for a loan or is otherwise restricted.

Name	Nature of Asset	*	Balance
Other Current Assets:	☐ Check if Not Applicable		
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
Total Other Current Assets (Line 6, Page 4) :			
Non-Current Assets:	☐ Check if Not Applicable		
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
Total Other Non-Current Assets (Line 13, Page 4):			
Other Fixed Assets:	☐ Check if Not Applicable		
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
Total Other Fixed Assets (Line 19, Page 4):			
TOTAL OTHER ASSETS:			

SCHEDULE E
NON-ADMITTED ASSETS

1.	Notes, Accounts Receivables or Advances:		
a.	From Affiliates		
b.	From Controlling Stockholder / Ownership Interest		
c.	From Directors / Officers		
d.	From Employees / Salesmen		
e.	From Others		
Total (Line 1, entries a through e):			
2.	Fixed Assets costing less than \$200 each or amortized longer than five years		
3.	Leasehold Improvements in excess of Statute authorization		
4.	Investments:		
a.	In Subsidiaries		
b.	In Affiliates of Parent / Ultimate Parent		
Total (Line 4, entries a and b):			
5.	Prepaid Expenses in excess of Liquidation Value		
6.	Deferred Expenses		
7.	Intangible Assets:		
a.	Goodwill		
b.	Franchises		
c.	Customer Lists		
d.	Patents or Trademarks		
e.	Agreements not to Compete		
f.	Others (Identify)		
Total (Line 7, entries a through f):			
8.	Any Other asset pledged as collateral or otherwise restricted		
9.	Other Assets not allowed by Statute (Identify)		
Total (Line 9, all entries):			
10.	TOTAL NON-ADMITTED ASSETS (Line 22, Page 4 and Line 23, Page 5)		

SCHEDULE F
NOTES PAYABLE

Place a check in the column marked with an asterisk (*) to designate Notes due to Affiliates, Directors, Officers, or Controlling Shareholder / Interest.

Description		Balance
Current Portion of Notes Payable:	☐ Check if Not Applicable *	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
Total Current Portion of Notes Payable (Line 4, Page 5):		
Long-Term Portion of Notes Payable:	☐ Check if Not Applicable *	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
Total Long-Term Portion of Notes Payable (Line 10, Page 5):		
TOTAL NOTES PAYABLE:		

Year Ending:

SCHEDULE G OTHER LIABILITIES

Name	Nature of Liability	Balance
Other Current Liabilities:	☐ Check if Not Applicable	
Total Other Current Liabilities (Line 7, Page 5):		
Other Long-Term Liabilities:	☐ Check if Not Applicable	
Total Other Long-Term Liabilities (Line 11, Page 5):		
TOTAL OTHER LIABILITIES:		

SCHEDULE H
FUNDED UNEARNED PREMIUM RESERVE
Chapter 634, Florida Statutes

List all assets used to meet the Unearned Premium Reserve requirement(s) for any warranty license(s) held by the Licensee. The reserve is required to be funded with unencumbered assets. The assets shall be held as prescribed under Chapter 625.301 - 625.340, Florida Statutes. (Attach additional pages, if needed.) Please identify any assets on deposit with the Department of Financial Services, Division of Treasury, Bureau of Collateral Management with check in the column marked with an asterisk (*).

Description of Asset	Maturity or Number of Shares	*	Market Value	Original Cost
Motor Vehicle Service Agreement Company			☐ Check if Not Applicable	
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
MOTOR VEHICLE SERVICE AGREEMENT COMPANY RESERVES:				
Home Warranty Association			☐ Check if Not Applicable	
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
HOME WARRANTY ASSOCIATION RESERVES:				
Service Warranty Association			☐ Check if Not Applicable	
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
SERVICE WARRANTY ASSOCIATION RESERVES:				
TOTAL RESERVES:				

EXHIBIT I
Recap of Premiums Written for 12 Months Ending
NATIONWIDE (Including FLORIDA)

	(A) 1-Year or Less Contracts	(B) 2-Year Contracts	(C) 3-Year Contracts	(D) 4-Year Contracts	(E) Others (5 Year or Longer)	(F) Totals
1. Gross Written Premium Current Year						
2. Less Cancellations and Refunds	()	()	()	()	()	()
3. Adjusted Premiums						

EXHIBIT II
Recap of In-Force Premiums
NATIONWIDE (Including FLORIDA)

	(A) Number of Warranties	(B) Premium Received and Outstanding	(C) Unearned Premium Reserve (UPR)	(D) Amount of Premium Covered by CLP **
1. In-Force end of prior year				
2. Audit adjustments to prior year				
3. Issued during the year				
4. Cancelled during the year	()	()	()	()
5. Expired during the year	()	()	()	()
6. Earned during the year			()	
7. In-Force end of current year			*	

* Amount must agree with Line 9a, Page 5 and the Total of Exhibit IV, Column E, Page 16.

** For companies with more than one CLP policy, attach a separate schedule listing the name and address of the insurer, the time period covered, the number of contracts and the total dollar amount covered by each policy.

PLEASE NOTE: Multiple policies of the same type of coverage are not permitted for the same time period.

EXHIBIT III
Recap of Earned Premiums
NATIONWIDE (Including FLORIDA)

	(A) Adjusted Premiums Written (from Exhibit I)	(B) Add Required UPR Prior Year	(C) Deduct Required UPR Current Year	(D) Premiums Earned (Enter on Line 1a, Current Year, Page 6)
1. Premiums Written				

EXHIBIT IV
Detail of Unearned Premium Reserve
NATIONWIDE (Including FLORIDA)

(A)	(B)	(C)	(D)	(E)	(F)
Calendar Year	Term Year	Premium Received and Outstanding on Warranties Not Covered by CLP	Gross Unearned Premium	Unearned Premium Reserve	Column E Divided By Column D
Current	1 or Less				
	2				
	3				
	4				
	5				
	Other				
	2				
	3				
	4				
	5				
	Other				
	3				
	4				
	5				
	Other				
	4				
	5				
	Other				
	5				
	Other				
	Other				
	Totals			*	%

* Amount must equal Unearned Premium Reserve column on Exhibit II, Page 15.

EXHIBIT V
Recap of FLORIDA Premium Written for the 12 Months Ending

	(A) 1-Year or Less Contracts	(B) 2-Year Contracts	(C) 3-Year Contracts	(D) 4-Year Contracts	(E) Others (5 Year or Longer)	(F) Totals
1. Gross Written Premium Current Year						
2. Less Cancellations and Refunds	()	()	()	()	()	()
3. Adjusted Premiums						

EXHIBIT VI
Recap of FLORIDA In-Force Premiums

	(A) Number of Warranties	(B) Premium Received and Outstanding	(C) Unearned Premium Reserve (UPR)	(D) Amount of Premium Covered by CLP
1. In-Force end of prior year				
2. Audit adjustments to prior year				
3. Issued during the year				
4. Cancelled during the year	()	()	()	()
5. Expired during the year	()	()	()	()
6. Earned during the year			()	
7. In-Force end of current year				

EXHIBIT VII
Recap of FLORIDA Earned Premiums

	(A) Adjusted Premiums Written (from Exhibit V)	(B) Add Required UPR Prior Year	(C) Deduct Required UPR Current Year	(D) Premiums Earned
1. Premiums Written				

EXHIBIT VII-A
Recap of 15% Reserve

1. Gross Unearned Premium, From Exhibit VIII, Column D, Page 18, x 50%	0
2. Line 1 x 15%	0
3. Less Statutory Deposit Held Under Section 643.052, F.S.	
4. Required Reserve to be Held by the Department of Financial Services, Division of Treasury, Bureau of Collateral Management Under Section 634.041, F.S.	0

Company Name:

Year Ending:

EXHIBIT VIII
Detail of FLORIDA Unearned Premium Reserve

(A)	(B)	(C)	(D)	(E)	(F)
Calendar Year	Term Year	Premium Received and Outstanding on Warranties Not Covered by CLP	Gross Unearned Premium	Unearned Premium Reserve	Column E Divided By Column D
Current	1 or Less				
	2				
	3				
	4				
	5				
	Other				
	2				
	3				
	4				
	5				
	Other				
	3				
	4				
	5				
	Other				
	4				
	5				
	Other				
	5				
	Other				
	Other				
	Totals			*	%

* Amount must equal Unearned Premium Reserve column on Exhibit VI, Page 17.

EXHIBIT IX
Reported Claims Incurred

Exclude All IBNR Claims	(A) Reported claims paid current year to date	(B) Total reported claims unpaid	(C) Reported claims unpaid at end of previous year	(D) Reported claims incurred current year (A+B-C=D)
1. Number				
2. Amount				

EXHIBIT X
Claims Adequacy

(A) Claims reserve previous year	(B) Claims paid during current year on claims incurred in previous years	(C) Excess or (deficiency) (A-B=C)

EXHIBIT XI
Compilation of Claims Payable / Reserve
(Page 6, Line 6a)

	(A) Claims incurred but not reported	(B) Claims reported but not paid	(C) Claims reserve (A+B=C)
1. Number			
2. Amount			

EXHIBIT XII
Ratios

1	Reported claims paid current year to date	Premium earned year to date	%
2	Reported claims incurred	Premium earned (Plus reserve investment income from Statement of Operations, Line 2a, Current Year, Page 6).	%

EXHIBIT XIII
Claims Exposure

	(A) Total Claims Paid	(B) Total Claims Covered by CLP	(C) % Claims Covered by CLP
1. Nationwide			%
2. Florida Only			%

EXHIBIT XIV
Itemized Agreement Acquisition Costs

	(A) Current	(B) Deferred	(C) Total
1. Commissions			
2. Administrative Fees			
3. Underwriting Costs			
4. Other *			
5. Totals			

* Provide detailed breakdown on additional page(s).

EXHIBIT XV
Premiums Written and Claims Paid by State

State	Is Company Licensed?	Gross Premiums Written	Claims Paid		Number of Claims Resisted
			Number	Amount	
	☐				
	☐				
	☐				
	☐				
	☐				
	☐				
	☐				
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	☐				
	☐				
	☐				
	☐				
	☐				
All Additional States *					
TOTALS:					

Company Name:

Year Ending:

LIST OF OFFICERS/DIRECTORS AND KEY PERSONNEL

Complete the following for all officers, directors, partners, members, and facility executive director/administrators. Include shareholders and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such person and/or shareholder has been appointed, elected, nominated, designated or has been added to this list during this report period, place a check in the "New" column provided. If required biographical information has not been previously submitted on those checked, please refer to the instructions provided at <http://www.floir.com/siteDocuments/OfficeDirector.pdf>.

Name	Position/Title	Residence Address	City	State/ Prov.	Zip/Postal Code	Date of Birth	%	New
								☐
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								☐

Company Name:

Year Ending:

LIST OF COMPANIES

Complete the following for all companies and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such company has been added to this list during this report period, place a check in the "New" column provided.

Name	Business Address	City	State/ Prov.	Zip/Postal Code	FEIN	%	New
							☐
							☐
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SAVE/SUBMIT PAGE

Save - Use this button to save your data to our server. **It is strongly recommended that you save your data periodically as you fill in this form.** You can still save your data even if you have validation errors appear below.

Submit Final - Use this button if you have entered all the required information and want to submit this data to our server. If you have validation errors, they must be corrected before being able to submit the form data. **Once you successfully submit the form data, you can no longer make changes.**

The session key will expire on:

Eastern Time

Save

Submit Final



Office of Insurance Regulation

FLORIDA
COMPANY CODE:
6 5 _ _ _ _

FEDERAL EMPLOYER
IDENTIFICATION NUMBER:
_ _ _ - _ _ _ _ _

ANNUAL REPORT FOR MOTOR VEHICLE MANUFACTURERS

(NAME OF THE MOTOR VEHICLE MANUFACTURER)

TO THE
OFFICE OF INSURANCE REGULATION
OF THE
STATE OF FLORIDA

200 East Gaines Street
Tallahassee, FL 32399 - 0331

FOR THE YEAR ENDED

_____, 2 0 _ _

GENERAL INFORMATION AND INSTRUCTIONS

1. This report must be filed electronically through the Regulatory Electronic Filing System (REFS). Paper reports are not accepted as complying with the filing requirement.
2. Either Adobe Reader 7.0.5 or higher, or Adobe Acrobat Standard/Professional 7.0.5 or higher is required to properly complete the filing. Further information is available at the following link:
http://www.floir.com/pdf/REFS_Adobe_LiveCycle_Instructions_r.pdf
3. A session key was assigned when you downloaded this report. This session key has an expiration date and time. **Any data that is not saved or submitted prior the expiration time will be lost.**
4. Please complete:
 - a. The **Invoice**, attach a check for the filing fee of \$100, and mail to the address shown on the **Invoice**. The payment must be received by the Office of Insurance Regulation no later than March 1. A copy of the invoice and check must be attached to this filing.
 - b. The **Request for Exemption from Examination** (Form OIR-A3-1985), attach a check for the filing fee of \$2,000 and mail to the address shown on the Invoice. The payment must be received by the Office of Insurance Regulation no later than March 1. A copy of the invoice and check must be attached to this filing.
5. Two boxes are shown in the upper right hand corner of each report page. Clicking on the box beside "Highlight Fields" shades all places in which data may be entered. Clicking on the box beside "Highlight Required Fields" shades those areas where data must be entered to submit the form, based on previous entries on the form.
6. Please enter all numeric fields with numbers only. Commas, dashes, dollar signs, are not permitted.
7. Unanswered questions and blank lines on schedules will not be accepted. If no answers or entries are to be made, enter "0" on all lines asking for a numeric response and "None" or "N/A" on all lines requesting a non-numeric response.
8. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the applicable report item. This additional information should be in electronic format (i.e. Word, Excel, PDF, etc) or, if in paper format, scanned in as a PDF, and should be uploaded and attached to the filing as the appropriate Component Named document or as a Miscellaneous Document. If posted as Miscellaneous Document, be sure to assign a descriptive Name to the document.
9. "Save" and "submit" buttons are provided on the last page of this report. Pressing the "s" key while pressing the "ALT" key will display the last page. Clicking the "Save" button will save the data to our website, but not to your computer. **It is strongly recommended that you save your data periodically as you fill in this form.** Confirmation messages are sent when data is successfully saved or submitted.
10. Saving or submitting causes data to be verified for completeness, and you will be notified if errors have occurred. Validation errors must be corrected in order to submit the data. Once the data is successfully submitted, changes or **additions must be made by amending the online filing.**
11. Please print, sign, notarize and scan the STATEMENT page (see next page); then upload the PDF version of the signed/notarized page as the **Signed Jurat Page.**

Company Name: _____

Period Ending: _____

Please see #11 of the Instructions Page.

Company Name: _____
Company FEIN: _____ Florida Company Code: _____ Period Ending Date: _____
State and Date of Incorporation/Organization: _____ (State/Prov): _____ (Date): _____
Date Licensed by the Office of Insurance Regulation: _____ (Date): _____
Date Commenced Business: _____ (Date): _____

Address of Home Office:

Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Address of Main Administrative Office:

Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Mailing Address:

Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Records Location (if different than Main Office):

Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____

Address of Principle Florida Office:

Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Website: _____

Type of entity (check one) ☐ Corporation – For profit ☐ Sole proprietorship
☐ Corporation – Not for profit ☐ Limited liability company
☐ Partnership ☐ Other: _____

Contact Name: _____
Contact Title: _____
Phone: _____ Ext: _____ Fax: _____
Email Address: _____

OFFICERS / DIRECTORS / MEMBERS

Show full name (initials not acceptable)

Chief Executive Officer _____
President _____
Vice President _____
Secretary _____
Treasurer / Chief Financial Officer _____
Chairman of the Board _____

Directors / Members

STATE OF: _____

COUNTY OF: _____

_____, President, _____, Secretary,
and _____, Chief Financial Officer (or corresponding person having charge of the
Financial records of the licensee, of the _____ being duly sworn
each for himself or herself deposes and says that they are the above-described officers of the said licensee, and that on the reporting period stated
above, all of the herein assets were the absolute property of the said licensee, free and clear from any liens or claims thereon, except as herein stated,
and that this report, together with related exhibits, schedules and explanations therein contained, annexed or referred to is a full and true statement of
all assets and liabilities and of the condition and affairs of the said licensee as of the reporting period stated above, and of its income and deductions for
the period reported.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

_____, day of _____, 20 _____
Notary Public: _____

Commissioner Number: _____

Expiration Date: _____

_____, President/Owner

_____, Secretary

_____, Treasurer/CFO

OIR-A3-1984

REV (5/21)

69O-200.016

Company Name:

Period Ending:

Print this page

EXHIBIT I**Recap of FLORIDA Premium Written for the 12 Months Ending __/__/__**

	1-Year or Less Contracts	2-Year Contracts	3-Year Contracts	4-Year Contracts	Others (5-Year or Longer)	Totals
Gross Written Premium Current Year	\$	\$	\$	\$	\$	\$
Less Cancellations and Refunds	()	()	()	()	()	()
Totals	\$	\$	\$	\$	\$	\$

EXHIBIT II**Recap of FLORIDA In-Force Premiums**

	Number Of Warranties	Premium Received and Outstanding	Unearned Premium Reserve (UPR)	Amount of Premium Covered By CLP
In-Force end of prior year		\$	\$	\$
Audit adjustments to prior year				
Issued during the year				
Cancelled during the year	()	()	()	()
Expired during the year	()	()	()	()
Earned during the year			()	
In-force end of current year		\$	\$	\$

EXHIBIT III**Reported Claims Incurred - FLORIDA**

EXCLUDING ALL IBNR CLAIMS	(1) Reported claims paid In the current year	(2) Total reported claims Unpaid	(3) Reported claims Unpaid at end of previous year	(4) Reported claims incurred current year (1+2-3=4)
Number				
Amount	\$	\$	\$	\$

Company Name:

Period Ending:

EXHIBIT VI
Claims Exposure - FLORIDA

	(1) Total Claims Paid	(2) Total Claims Covered by CLP	(3) % of Claims Covered by CLP
Florida	\$	\$	%

Company Name:

Period Ending:

LIST OF OFFICERS/DIRECTORS AND KEY PERSONNEL

Complete the following for all officers, directors, partners, members, and facility executive director/administrators. Include shareholders and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such person and/or shareholder has been appointed, elected, nominated, designated or has been added to this list during this report period, place a check in the "New" column provided. If required biographical information has not been previously submitted on those checked, please refer to the instructions provided at <http://www.floir.com/pdf/OfficeDirector.pdf>.

Name	Position/Title	Residence Address	City	State/ Prov.	Zip/Postal Code	Date of Birth	%	New
								☐
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								☐
								☐
								☐

Company Name:

Period Ending:

LIST OF COMPANIES

Complete the following for all companies and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such company has been added to this list during this report period, place a check in the "New" column provided.

Name	Business Address	City	State/ Prov.	Zip/Postal Code	FEIN	%	New
							☐
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Company Name:

Period Ending:

SAVE/SUBMIT PAGE

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The session key will expire on: Eastern Time

Save

Submit Final

SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

☐ Original Designation ☐ Insurer Name Change ☐ Merger / Acquisition ☐ Update Delivery Information

Insurer or Company Name: _____

Previous Name (If applicable): _____

Home Office Address: _____

City, State, Zip _____

FEI # _____

FL Company Code _____

Telephone # _____

Know all men by these present, that the insurer or other entity named above is subject to the statutory agent for service of process provisions of the Florida Insurance Code duly organized and existing under and by virtue of the laws of the state of domicile.

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in any county in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof.

The undersigned hereby further agrees and stipulates that this agreement is and shall remain irrevocable, so long as there is liability, under any policy, claim or cause of action within this state, either fixed or contingent. Said insurer or other entity does hereby designate the following as the name and address of the person to whom all process is to be forwarded when process is served upon said Chief Financial Officer of the State of Florida on behalf of the above named insurer or entity. **In the event of a change in the name of the insurer or the designation of the person to whom process is to be forwarded, whether it be name, address, and/or phone or fax numbers, the insurer or company shall immediately file a new agreement form with the Chief Financial Officer of the State of Florida at the address shown at the bottom of this page.**

**Designated Person
to receive process:** _____

E-Mail Address: _____

Phone#: _____ **Fax#:** _____

Mailing Address: _____

Street Address: _____

Signature: _____

I hereby consent and agree to be the person to whom process served upon the Chief Financial Officer of the State of Florida for said entity, may be forwarded.

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of said insurer or other entity, being duly authorized by the Board of Directors or governing body of this entity to execute this document, have hereunto set our hands and affixed the seal of said insurer or other entity on this the _____ day of _____, A.D. _____.

President or CEO's Signature

President or CEO's Name (Typed or Printed)

SEAL

Secretary's Signature

Secretary's Name (Typed or Printed)

Any signatures other than the President, CEO, or Secretary for the Company must be validated by the attachment of a resolution of the Board of Directors or Governing body of said company delegating the authority to sign for the company.

OIR-C1-144

Rev 06/2004

Rules 69O-193.003, 69O-200.004

Service of Process Section

200 East Gaines Street • PO Box 6200 • Tallahassee, FL 32314-6200 • (850) 413-4200 • Fax (850) 922-2544



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail ONLY completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL



Florida Office of Insurance Regulation

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in searchable PDF format unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <https://www.floir.com/iportal> and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

<https://www.floir.com/iportal>

Any questions Applicants have concerning this application packet or iApply may be directed to Property and Casualty at pcappcoord@floir.com.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

INSTRUCTIONS

SECTION I - APPLICATION FEES

Section I-1 **Application Fees**

Applicants* must pay a license fee of \$100 U.S. Dollars ("USD"), pursuant to Sections 634.061 and 634.071, Florida Statutes. This fee is due at the time the application packet is filed and is not refundable.

Secure your check to the Invoice on page 14 of this application and mail to:

Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

Include copies of the completed Invoice and check with your application filing submitted via iApply. This procedure will expedite the processing of your application and assure a timely recording of the fee payment.

Section I-II **Fingerprint Fees**

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions.

*See Section IV-5 on page 8 of this Application for entities wishing to apply as a Motor Vehicle Manufacturer rather than a Motor Vehicle Service Agreement Company.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit a copy of Applicant's Articles of Incorporation or Partnership Agreement, unless entity is a sole proprietorship, complete with all amendments, and certified within the last year by the public official with whom the originals are on file in the state or jurisdiction of domicile. Partnership Agreements that are not on file in the jurisdiction of domicile should be certified as true and correct by one of the partners.

Section II-2 Certificate of Status from State of Domicile

If Applicant is not a Florida domestic company, submit a certificate of status from the domiciliary jurisdiction dated within the last year. A certificate of status is a document issued by the public official having supervision of the records of corporations in the Applicant's home state or jurisdiction of domicile, usually the Secretary of State or equivalent office, that shows the company is duly organized in the state or jurisdiction of domicile and that all taxes and fees have been paid.

Section II-3 Certificate of Status from Florida

Submit a certificate of status from the Florida Secretary of State dated within the last year.

Section II-4 Company Bylaws

Submit a copy of Applicant's Bylaws or equivalent document, if any. This document should be certified by Applicant's Secretary, or equivalent position, as a true and correct copy of the current document and dated within the last year. Only the Secretary's signature will be accepted, unless this position does not exist.

Section II-5 Service of Process Consent and Agreement

Submit the executed Service of Process Consent and Agreement Form OIR-C1-144. No signatures other than those of the President or Chief Executive Officer and the Secretary will be accepted.

Section II-6 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

Section II-7 Fictitious Name Filing

If the organization plans to utilize a fictitious name, submit evidence of compliance with Section 865.09, Florida Statutes.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

INSTRUCTIONS SECTION III – FINANCIAL

Section III-1 **Financial Statements**

Applicant must provide the most recent financial statement reflecting minimum net assets maintained in the United States of at least \$500,000 USD, and contain a balance sheet, income statement, and statement of cash flows. These statements should be certified as true and correct by two officers and may not be more than 12 months old. Applicant should also submit the same for its immediate parent.

Section III-2 **Financial Requirements**

1. Applicant must comply with one of the following two options:
 - a. Supply the Office with a copy of an approved executed contractual liability insurance policy as set forth in Section 634.041(8)(b), Florida Statutes. The insurance company issuing the policy must be a Florida admitted property and casualty insurance company whose Certificate of Authority allows it to write this type of policy. Policies issued by Surplus Lines insurers are not acceptable; **or**
 - b. Supply the Office with a sworn statement of Applicant's intentions to establish and maintain a 50% reserve as outlined by Section 634.041(8)(a), Florida Statutes. Applicants choosing this option must also place a deposit with Bureau of Collateral Management (see instructions in III-3 below) equal to 15% of unearned premium reserve, as explained in Section 634.041(8)(a)(3), Florida Statutes.

Section III-3 **Deposit**

Pursuant to Section 634.052, Florida Statutes, Applicant must, prior to the issuance of a license, provide evidence of the appropriate deposit or security bond as below.

- a. If Applicant has \$750,000 USD or less in unearned gross written premiums it shall place with the Bureau of Collateral Management a deposit of at least \$100,000 USD.
- b. If Applicant has more than \$750,000 USD in unearned gross written premiums it shall place with the Bureau of Collateral Management a deposit of at least \$200,000 USD.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

Deposits should be made in accordance with the provisions of Section 625.52, Florida Statutes. For information on how to make the required securities deposit, contact the Bureau of Collateral Management at (850) 413-3167, or:

Florida Department of Financial Services
Bureau of Collateral Management
200 East Gaines Street
Tallahassee, FL 32399-0345

Section III-4 **Plan of Operations**

It is important for the Office to have a clear understanding of the proposed operations of the specialty insurer and the goals it seeks to achieve. To fulfill this requirement, the plan of operations must consist of the following information:

- a. **History:** Applicant should prepare a brief history of the company since its incorporation. Indicate any changes of ownership or changes in operations. Indicate any actions taken by governmental agencies that have or had jurisdiction over the company.

In this section list all companies or individuals affiliated with the Applicant. If a company, indicate what its principal business is. In addition, provide a list of all d/b/a's, trade names, or fictitious names, plan or contract names, or any other name the general public may recognize.

- b. **Organizational Chart:** Furnish a complete organizational chart for Applicant fully disclosing the relationship between all entities in the organizational structure, including all parent, holding, and subsidiary entities, as well as any and all affiliated entities, and clearly stating all ownership percentages, if applicable.
- c. **Management:** Applicant should provide information regarding the motor vehicle service warranty experience of individuals in key areas of management and should outline specifically how each of the following will be handled: marketing, claims handling, accounting, and investments.
- d. **Products:** Applicant should give a description of each product it plans to market.
- e. **Marketing and Growth:** Applicant should furnish a plan of marketing including methods, rates, commissions, projected growth pattern, and other pertinent information affecting marketing plans.
- f. **Administration:** If Applicant chooses to use an administrator, the administrator must also obtain licensure as a Motor Vehicle Service Agreement Company, pursuant Section 634.031, Florida Statutes.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

Section III-5 States Where Applicant is Currently Doing Business

Applicant should provide a list of states in which it conducts motor vehicle service warranty business.

Section III-6 Financial Projections

Applicant should submit projected total premiums for the first three years of operation from the time of expected licensure. Submissions should include the underlying assumptions, the projected number of contracts sold, and the average premium under each type of contract. This information should be provided for Florida only, as well as separately for all business.

Section III-7 Alphabetical List of Proposed Sales Representatives

Applicant should provide a list of its proposed sales representatives. It is understood that most applicants do not have a complete sales force in place; however, this information should be provided to the best of your ability.

Information on the licensing of sales representatives may be obtained from the Florida Department of Financial Services, Division of Agent & Agency Services, by calling 1-877-MY-FL-CFO (1-877-693-5236), or (850) 413-3089, if calling from out of state.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

SECTION IV – MANAGEMENT

Section IV-1 Management Information Forms

Submit Management Information Form OIR-C1-2221 fully describing Applicant's management, ownership, and all individuals or entities having direct or indirect control up to and including any 10% or greater interest holders of the ultimate parent. A Management Information Form should be submitted for each entity in the ownership chain.

Forms should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

Section IV-2 Biographical Affidavits as to Officers, Directors, and Shareholders

Provide a National Association of Insurance Commissioners ("NAIC") Biographical Affidavit (NAIC Form 11) (Form OIR-C1-1423) for each individual listed in Section IV-1. Applicant may omit individuals for those companies in the organizational structure between the immediate parent and the ultimate parent. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

All questions must be answered. All "Yes" answers must be explained.

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

Section IV-3 Background Investigative Report

A Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, included in this packet.

The NAIC approved background investigation vendor list can be found at:

https://www.naic.org/documents/industry_ucaa_third_party.pdf

Section IV-4 Fingerprint Cards

Fingerprint cards must be provided to the Office for each person for whom a Biographical Affidavit is required. Please refer to Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions. If an individual has submitted a fingerprint card dated within 5 years of the date of the Application filing, a fingerprint card need not be submitted for that individual.

Section IV-5 Motor Vehicle Manufacturers

Entities that qualify as Motor Vehicle Manufacturers pursuant to Section 634.011(7), Florida Statutes, may apply for licensure in accordance with Section 634.041(12), Florida Statutes.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

CHECKLIST

SECTION I - APPLICATION FORM & FEES

Applicant Name: _____

Federal Identification Number ("FEIN"): _____

Home Office Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

- ☐ 1. Application fee paid
 - ☐ a. Copy of invoice included (page 14 of this form)
 - ☐ b. Copy of check
- ☐ 2. All fingerprint fees paid electronically
 - ☐ a. Copies of online payment confirmation

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

CHECKLIST

SECTION II – LEGAL

- ☐ 1. Articles of Incorporation or Partnership Agreement (if applicable)
 - ☐ a. Appropriately Certified
- ☐ 2. Certificate of Status from Domiciliary Jurisdiction (if applicable)
- ☐ 3. Certificate of Status from Florida
- ☐ 4. Company Bylaws or equivalent (if applicable)
 - ☐ a. Certified by Secretary
- ☐ 5. Service of Process Consent and Agreement Form OIR-C1-144
- ☐ 6. Authorization Letter (if applicable)
- ☐ 7. Fictitious Name Filing (if applicable)

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

CHECKLIST

SECTION III – FINANCIAL

- ☐ 1. Financial Statements
 - ☐ a. Balance Sheet
 - ☐ b. Income Statement
 - ☐ c. Statement of Cash Flows
 - ☐ d. Certified by 2 Officers
 - ☐ e. Not more than 12 months old
 - ☐ f. Provided for Parent (as applicable)
- ☐ 2. Financial Requirements (a **or** b)
 - ☐ a. Executed Contractual Liability Policy, **or**
 - ☐ b. A sworn statement to establish and maintain an unearned premium reserve
- ☐ 3. Securities Deposit
 - ☐ a. Appropriate security deposit (see page 4); **or**
- ☐ 4. Plan of Operations
 - ☐ a. History
 - ☐ b. Organizational Chart
 - ☐ c. Management
 - ☐ d. Products
 - ☐ e. Marketing and Growth
- ☐ 5. List of states where Applicant and affiliates are currently doing business
- ☐ 6. Financial Projections for 3 years
 - ☐ a. Florida
 - ☐ b. Nationwide
- ☐ 7. Alphabetical List of Proposed Sales Representatives

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

CHECKLIST

SECTION IV – MANAGEMENT

- ☐ 1. Management Information (Form OIR-C1-2221) submitted for all required entities
- ☐ 2. Biographical affidavits (Form OIR-C1-1423) submitted for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. “Yes” answers explained
 - ☐ c. Signed
 - ☐ d. Notarized
- ☐ 3. Background investigative reports for all required individuals. The reports must be based on the Biographical Affidavits submitted to the Office with this Application.
 - ☐ a. Proof of order and confirmation of payment submitted to the Office
- ☐ 4. Fingerprint cards for all required individuals
 - ☐ a. All information completed (no blanks)
 - ☐ b. Signed

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

APPLICATION CERTIFICATION

The below certification must be executed by two officers of Applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary*.

The undersigned state that they are officers having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to seek licensure as a Motor Vehicle Service Agreement Company or Manufacturer; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers will be accepted only if the applicant does not have these positions.

APPLICATION FOR LICENSE MOTOR VEHICLE SERVICE AGREEMENT COMPANY

INVOICE

NAME OF COMPANY: _____

FEIN: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

MAILING ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS ABOVE):

(city)

(state)

(zip code)

1. Make payable to the Department of Financial Services and mail check and invoice only to:

Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

FOR DEPARTMENT USE ONLY

RECEIPT#	AMOUNT	TYPE	CLASS	FUND	AMOUNT	SOURCE	
	\$100.00	10	33	3	00	2	
LICENSE NUMBER	Dated MO DAY YR			Mailed MO DAY YR			MAILED BY



OFFICE OF INSURANCE REGULATION
Company Admissions

LIST OF PROPOSED SALES REPRESENTATIVES

COMPANY
NAME: _____

NAME:

ADDRESS:

SSN:

NAIC No.: _____ FEIN: _____

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Form A: <See UCAA FAQs for details> **UCAA Type:** <See UCAA FAQs for details> **Other:** <See UCAA FAQs for details>

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

Address: City:

State/Province: Postal Code: Phone:

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

Yes  No 

Yes  No 

If yes, what country? _____

3. Affiant's occupation or profession: _____

4. Affiant's business address:

Business telephone: _____ Business Email: _____

[illegible]

Graduate Studies	College/University	City/State	Dates Attended (MM/YY)	Degree Obtained

[illegible]

Revised 12/08/2020

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Present or proposed position with the Applicant Company: _____

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐ ☐ No ☐ ☐

If any claims were made on the bond, give details: _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐ ☐ No ☐ ☐

If yes, give details: _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes ☐ ☐ No ☐ ☐

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

- b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ ☐ No ☐ ☐

- c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ ☐ No ☐ ☐

- d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ ☐ No ☐ ☐

- e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ ☐ No ☐ ☐

- f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ ☐ No ☐ ☐

- g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ ☐ No ☐ ☐

- h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ ☐ No ☐ ☐

- i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ ☐ No ☐ ☐

- j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ ☐ No ☐ ☐

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details. _____

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☐

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details: _____

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☐

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☐

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☐ No ☐

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

BIOGRAPHICAL AFFIDAVIT Supplemental Personal Information

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: <See UCAA FAQs for details> ☐ **UCAA Type:** <See UCAA FAQs for details> ☐ **Other:** <See UCAA FAQs for details>

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
Address: <Enter Applicant Company Address> City: <Enter Applicant Company City>
State/Province: <Enter Applicant Company State/Province> Postal Code: <Enter App. Co. > ☐ Phone: <Enter App. Co. > ☐

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ ☐ No ☐ ☐

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

4. Government Identification Number if not a U.S. Citizen:

<u>Government ID Number:</u>	<u>Country of Issuance:</u>
_____	_____
_____	_____
_____	_____

5. Foreign Student ID# (if applicable) : _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

6. Date of Birth: (MM/DD/YY) : _____ Place of Birth, City: _____
State/Province: _____ Country: _____

7. Name of Affiant's Spouse (if applicable) : _____

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: FEIN:

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact

[company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: County of:

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.:

FEIN:

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ [name of CRA, address] ("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐

By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and: ☐ who is personally known to me, or ☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

NAIC No.: _____ FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

OIR-C1-2221

Rev.: 6/20

Rule: 690-200.004

CHAPTER 690-202

DONOR ANNUITY ORGANIZATIONS

690-202.001	Purpose and Scope
690-202.005	Notification of Acquisition, Merger and Name Change
690-202.008	General Eligibility Requirements
690-202.012	Annual Statement
690-202.015	Forms Incorporated by Reference

690-202.001 Purpose and Scope.

~~The purpose of this rule chapter is to implement the provisions of section 627.481, F.S., to regulate issuers of donor annuity agreements in Florida.~~

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 627.481 FS. History—New 7-15-90, Formerly 4-117.001, Amended 1-7-97, Formerly 4-202.001.

690-202.005 Notification of Acquisition, Merger and Name Change.

~~Donor annuity agreement issuers shall notify the Office in writing within 5 days from the date of a change in the corporate name, fictitious name or organization name of a registered issuer.~~

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.321(1), 627.481 FS. History—New 1-7-97, Formerly 4-202.005.

690-202.008 General Eligibility Requirements.

(1) Any person engaging in the business of issuing donor annuity agreements must submit Form OIR-C1-1208 to the Office electronically at <https://www.floir.com/iportal> on the date on which the person enters into the first of these annuity agreements. Form OIR-C1-1208, “Notification to the Florida Office of Insurance Regulation as a Qualifying Issuer of Donor Annuity Agreements Pursuant to section 627.481, F.S.,” effective 6/20, is hereby incorporated by reference and available at www.flrules.org/XXXXX, notify the Office in writing in a form prescribed by the Office in Form OIR-C1-1208, Notification to the Florida Office of Insurance Regulation as a Qualifying Issuer of Donor Annuity Agreements Pursuant to section 627.481, F.S., adopted in paragraph 690-202.015(1)(a), F.A.C. The notice must be made on the date on which the person first enters into a donor annuity agreement.

(2) Any person subject to section 627.481, F.S., that fails to submit the required notification form is subject to penalty as provided in section 626.9521, F.S.

Rulemaking Authority 624.308(1), 627.481(11) FS. Law Implemented 624.307(4), 627.481 FS. History—New 6-23-92, Amended 1-7-97, 12-24-03, Formerly 4-202.008.

690-202.012 Annual Statement.

(1) Within 60 days of the end of each fiscal year, each qualifying issuer of donor annuity agreements in this state must submit ~~a sworn statement on the form prescribed by the Office in Form OIR-A3-1209, “Sworn Statement in Lieu of Annual Statements for Issuers of Donor Annuity Agreements,” effective 6/20, which is hereby incorporated by reference and available at www.flrules.org/XXXXX adopted in paragraph 690-202.015(1)(c), F.A.C., attesting that the issuer has met all requirements of law. Form OIR-A3-1209 shall be submitted to the Office electronically at <https://www.floir.com/iportal>.~~

(2) Issuers that fail to submit the sworn statement in subsection (1) shall submit audited financial statements, and any information relating to the operations of the issuer necessary to determine compliance.

Rulemaking Authority 624.308(1), 627.481(11) FS. Law Implemented 624.307, 624.307(4), 627.481 FS. History—New 6-23-92, Amended 1-7-97, 12-24-03, Formerly 4-202.012.

690-202.015 Forms Incorporated by Reference.

(1) ~~The following forms are incorporated by reference to implement the provisions of Section 627.481, F.S.:~~

Title	Form Number

(a) Notification to the Office of Insurance Regulation as a Qualifying Issuer of Donor Annuity Agreements Pursuant to section 627.481, F.S.	OIR-C1-1208 http://www.flrules.org/Gateway/reference.asp?No=Ref-08286 (rev. 01/17)
(b) Sworn Statement in Lieu of Annual Statements For Issuers of Donor Annuity Agreements	OIR-A3-1209 http://www.flrules.org/Gateway/reference.asp?No=Ref-08289 (rev. 01/17)

(2) Copies of the forms may be obtained from the Office of Insurance Regulation's website at <http://www.flor.com/portal>.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 627.481 FS. History—New 7-15-90, Formerly 4-117.015, Amended 6-23-92, 1-7-97, 12-24-03, Formerly 4-202.015, Amended 7-30-17.

SWORN STATEMENT IN LIEU OF ANNUAL STATEMENTS
FOR ISSUERS OF DONOR ANNUITY AGREEMENTS

Donor Annuity Issuer's Name: _____

Street: _____

City: _____ State/Prov: _____ Zip/Postal: _____

Phone: _____ Ext: _____ Fax: _____

Email Address: _____

Donor Annuity Issuer's Contact Person: _____

Donor Annuity Issuer's FEIN: _____

STATE OF: _____

COUNTY OF: _____

_____, _____ (both printed please), of the above named issuer, being duly sworn, each deposes and says that they are the above described officers of the said issuer, and that on _____, which is the fiscal year-end, the issuer has met all of the requirements of Section 627.481, FS., and Chapter 69O-202, Florida Administrative Code.

(Typed Name)

(Signature)

(Title)

Subscribed and sworn to before me
by means of ☐ physical presence
or ☐ online notarization

This _____ day of _____, 20__

Notary Public: _____
Commission
Number: _____

Expiration Date: _____
☐ Personally Known or
☐ Produced Identification

(Type of Identification Produced)

(Typed Name)

(Signature)

(Title)

Subscribed and sworn to before me
by means of ☐ physical presence
or ☐ online notarization

This _____ day of _____, 20__

Notary Public: _____
Commission
Number: _____

Expiration Date: _____
☐ Personally Known or
☐ Produced Identification

(Type of Identification Produced)

For Office Use Only

Name Change ☐ FEIN Change ☐ Filing Period ☐

Print this page

SAVE/SUBMIT PAGE

Save - Use this button to save your data to our server. **It is strongly recommended that you save your data periodically as you fill in this form.** You can still save your data even if you have validation errors appear below.

Submit Final - Use this button if you have entered all the required information and want to submit this data to our server. If you have validation errors, they must be corrected before being able to submit the form data. **Once you successfully submit the form data, you can no longer make changes.**

When you have completed a form and selected "Submit Final," your report form is uploaded as a "Completed" document to your Component List; this does not submit the report to the Office of Insurance Regulation. Upon completion of all required items, the "Begin Submission Process" button (bottom right of the screen) will activate.

You must select and complete the "Begin Submission Process" to successfully submit your entire filing to OIR.

The session key will expire on: Eastern Time

Save

Submit Final



OFFICE OF INSURANCE REGULATION
Company Admissions

**NOTIFICATION TO THE OFFICE OF INSURANCE REGULATION AS A
QUALIFYING ISSUER OF DONOR ANNUITY AGREEMENTS PURSUANT TO
SECTION 627.481, F.S.**

Donor Annuity Issuer's Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ - _____

Phone: () - _____ **Fax:** () - _____

Email Address: _____

Fiscal Year-end: _____

State of Domicile: _____

Donor Annuity Issuer's Contact Person: _____

Donor Annuity Issuer's FEIN: _____

represented by _____ (name) _____ (position)

and _____ (name) _____ (position)

hereby notify the **Office of Insurance Regulation** and say by action of its trustees, and as represented by the two officers/directors with board voting privileges that the issuing entity intends to enter into donor annuity agreements in the State of Florida as allowed by Section 627.481, FS.

The Representatives certify that the Issuer **(check one)**:

a) ☐ has been in active operation for at least five years prior thereto and has qualified as an exempt organization under the Internal Revenue Code, 26 U.S.C. s. 501(c)(3); OR

b) ☐ has been wholly controlled for at least 10 years by a corporation or trust qualified under paragraph (a), if the subunit has been a corporation or trust for at least 2 years, and has engaged in the selling of annuity agreements authorized under this section in at least three other states without complaint.



OFFICE OF INSURANCE REGULATION
Company Admissions

**NOTIFICATION TO THE OFFICE OF INSURANCE REGULATION AS A
QUALIFYING ISSUER OF DONOR ANNUITY AGREEMENTS PURSUANT TO
SECTION 627.481, F.S.**

The Representatives further certify that:

1) All annuity benefits will be calculated to return to the Issuer upon the death of the donor a residue at least equal to one-half the original gift or other consideration under any such donor annuity agreement issued under Section 627.481, FS.

2) The Issuer will maintain admitted assets at least equal to the sum of the reserves on its outstanding donor annuity agreements, and a surplus of 10 percent of such reserves, calculated pursuant to Sections 627.481(2)(a) 1–3, FS, less any properly reinsured annuity risk.

3) The Issuer in an amount at least equal to the sum of such reserves and surplus will invest only in mutual funds or investments permitted under part II of chapter 625, FS, pursuant to the conditions of Section 627.481(2)(c) 2, FS, and such assets are segregated as separate and distinct funds, independent of all other funds and not applied for the payment of the debts and obligations of the Issuer for any other purpose other than the annuity benefits specified in Section 627.481, FS. Foreign Issuers may invest in the kind of securities permitted by the laws of the state in which incorporated or organized.

4) All donor annuity agreements issued will contain the clause: "This annuity is not issued by an insurance company, is subject only to limited regulation by the State of Florida and is not protected or otherwise guaranteed by any government agency."

5) Any donor annuity agreements entered into by the Issuer to support state institutions of higher learning will contain the clause: "This agreement is the entire contract between the parties, with rights and responsibilities of each party to the other as set forth herein. The donor or annuitant shall not have recourse against any assets of the state other than any funds or assets donated by, or funds derived from any assets donated by, the donor as set forth herein."

6) Charitable remainder unitrust trusts, charitable remainder annuity trusts, charitable lead trusts, pooled income funds or other similar charitable split interest trusts are only exempt from subsections (1), (2), (3), and (5), of Section 627.481, FS. and;

7) Provisions of part IX of Chapter 626, FS, known as *Unfair Insurance Trade Practices*, apply to issuers of donor annuity agreements under Section 627.481, FS.

The Representatives certify the Issuer is in compliance with all statutes governing the issuance of donor annuity agreements in the State of Florida.

for the ***Issuer***

BY: _____

(signed)

, DATED: _____

BY: _____

(signed)

, DATED: _____

(CORPORATE SEAL)

690-203.010 Scope.

~~The following rules developed by the Office of Insurance Regulation govern the issuance of a Certificate of Authority and the operation of a prepaid limited health service organization pursuant to the authority set forth in chapter 636, F.S.~~

Rulemaking Authority 636.067 FS. Law Implemented Chapter 636 FS. History–New 11-15-94, Formerly 4-203.010. Repealed.

690-203.013 Definitions for the Purpose of These Rules.

(1) All terms defined in the Prepaid Limited Health Service Organization Act, chapter 636, F.S., which are used in these rules shall have the same meaning as in the Act.

(2) Advertising. This includes, ~~but is not limited to~~, printed and published material, descriptive literature and sales aids, sales talks and sales materials, booklets, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television, or direct mail advertising. This includes any material or information intended to solicit or induce membership or the purchase of a limited health service plan.

(3) Co-payment. A specific dollar amount or percentage discount as specified in a subscriber contract, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services.

(4) Emergency Services. Services which are needed immediately because of an injury or unforeseen medical condition as provided for in the Subscriber Contract.

(5) PLHSO. Prepaid Limited Health Service Organization shall be abbreviated as PLHSO in these rules.

(6) Premium. The contracted sum paid by or on behalf of a subscriber or group of subscribers on a prepaid per capita or a prepaid aggregate basis for limited health services rendered by or through the PLHSO.

~~(7) Complete Application. An application for a certificate of authority that contains all of the items specified in rule 690-203.020, F.A.C., and Form OIR-1119 (rev. 8/94) "Application for Certificate of Authority," incorporated by reference in rule 690-203.100, F.A.C. The application must be completed in accordance with Chapter 636, F.S., and these rules in the manner specified within the application in order for each individual item to be considered complete for the purpose of determining that a properly completed application has been filed.~~

~~(7)(8)~~ Waiting Period. Waiting period shall relate to that period of time which may be specified in the contract and which must follow the date a person is initially covered under the contract before coverage shall become effective as to such person.

~~(8)(9)~~ Pre-Existing Condition or Illness. A condition, or symptoms thereof, which was diagnosed and for which the individual received medical advice or treatment from a physician within a 3 month period preceding the effective date of coverage.

~~(9)(10)~~ Prepayment. Any premium paid by or on behalf of a subscriber which entitles the subscriber to access to limited health services.

Rulemaking Authority 636.067 FS. Law Implemented 636.003, 636.008, 636.009, 636.015, 636.016 FS. History–New 11-15-94, Formerly 4-203.013. Amended

690-203.020 Prepaid Limited Health Service Organization Application for Certificate of Authority.

Substantial rewording of Rule 690-203.020, F.A.C. follows. See Florida Administrative Code for present text.

(1) A person applying for a certificate of authority as a prepaid limited service organization shall submit the following:

(a) Form OIR-C1-1119, "Application for Certificate of Authority Prepaid Limited Health Service Organization," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(b) Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(c) Form OIR-C1-938, "Fingerprint Payment and Submission Procedures," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(d) Form OIR-1423, "Biographical Affidavit," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX.

(2) A person shall submit the forms listed in subsection (1) electronically via the Office's iApply system at <https://www.floir.com/iportal>.

~~An application, Form number OIR C1 1119, incorporated by reference, in rule 69O-203.100, F.A.C., accompanied by the appropriate filing fee, shall be completed by each entity desiring to obtain a certificate of authority as a PLHSO. The applicant shall specify in the application the contact person or persons for the PLHSO for purposes of corresponding between the Office and the PLHSO concerning the application. During the investigation of the application, only contact persons specified by the PLHSO shall be permitted access to the application materials submitted. The applicant shall address correspondence to the Application Coordination Section, Insurer Services Support, Office of Insurance Regulation, Tallahassee, Florida 32399-0332. The Office shall accept and begin its investigation of an application promptly after receiving it. All application reviews will be conducted pursuant to chapter 120, F.S.~~

Rulemaking Authority 636.067 FS. Law Implemented 636.005, 636.007, 636.008, 636.009 FS. History—New 11-15-94, Formerly 4-203.020. Amended _____.

69O-203.021 Standards for Fingerprint Cards for New Applicants and Acquisition Applications.

~~(1) Fingerprints shall be submitted only on a card, for which instructions are adopted in subsection 69O-203.100(9), F.A.C., provided by the Office of Insurance. Others will not be accepted.~~

~~(2) The Office has adopted Form OIR-938 (rev. 4/91), incorporated by reference in rule 69O-203.100, F.A.C., which provides instructions on how fingerprint cards are to be completed.~~

Rulemaking Authority 636.067 FS. Law Implemented 636.007, 636.008 FS. History—New 11-15-94, Formerly 4-203.021. Repealed, _____.

69O-203.065 Reinsurance (Excess Loss Insurance).

PLHSOs may obtain reinsurance (excess loss insurance) in order to limit the PLHSO's financial risk. All excess loss or reinsurance contracts shall be filed with and approved by the Office. In addition to the regular insurance filing of any reinsurance (excess loss insurance) contract, if the reinsurance (excess loss insurance) contract contains insolvency protection for the PLHSO, the contract shall be submitted for prior approval to the Office of Insurance Regulation, Life and Health Financial Oversight, electronically through <http://www.flor.com/iportal>, Bureau of Life and Health Insurer Solvency Office of Insurance Regulation, Tallahassee, Florida 32399-0327.

Rulemaking Authority 636.067 FS. Law Implemented 636.009 FS. History—New 11-15-94, Formerly 4-203.065. Amended _____.

69O-203.070 Annual and Quarterly Reports.

(1) Each PLHSO shall file with the Office a full and true report of its financial condition, transactions, and affairs.

(a) An Annual Report covering the preceding fiscal year shall be filed on or before April 1 or within 3 months of the end of the reporting period of the clinic. Pursuant to Section 636.043, F.S., each PLHSO shall furnish to the Office an annual report by April 1, or within 3 months after the end of the reporting period on NAIC Annual Statement Health Blanks as adopted in Rule 69O-137.001, F.A.C.

1. The Annual Report shall be transmitted electronically to the National Association of Insurance Commissioners and that the executed Jurat page of said report has been transmitted electronically to the Office via the Regulatory Electronic Filing System, "REFS." The date affixed by the Office's electronic data processing system shall serve as evidence of the timeliness of the Annual Report. An Annual Report in any other format shall not be submitted to the Office.

2. Each PLHSO shall submit its Annual Report electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions incorporated by reference in paragraph 69O-137.001(3)(b), F.A.C.

3. The Annual Report shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(a), F.A.C.

4. Copies of the manuals are available:

a. From the National Association of Insurance Commissioners at <http://www.naic.org>; and,
b. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.

(b) Form OIR-A2-949, "Annual Report Contracts Issued & Outstanding," effective 12/20, hereby incorporated by reference and available www.flrules.org/XXXXX. Form OIR-A2-949 shall be submitted electronically on or

before April 1 or within 3 months of the end of the reporting period of the clinic via the Office's system at <https://www.flair.com/portal>.

(c) Form OIR-A2-950, "Annual Report Damage Claims & Medical Injury," effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX. Form OIR-A2-950 shall be submitted electronically on or before April 1 or within 3 months of the end of the reporting period of the clinic via the Office's system at <https://www.flair.com/portal>.

(d)(b) The completed Annual Reports ~~annual statement form~~ shall be accompanied by the items required in section 636.043, F.S., and an organization chart of the PLHSO identifying ownership and affiliated parent and subsidiary companies.

(2) Each PLHSO ~~or applicant~~ shall notify the Office of any legal proceeding, excluding traffic infractions, involving any person subject to providing biographical information. This shall include, ~~but not be limited to~~, any and all criminal, civil, and administrative actions entered by any state or federal entity and to include pending but yet unresolved actions.

(3) Any PLHSO which has operations in states other than Florida shall file its Annual Report ~~annual report~~ based upon its total operations. In addition, the PLHSO shall file a separate schedule of all financial statements specified in the Annual Report ~~annual report form~~, including the audited financial statement, which covers the Florida operations only.

(4) If a PLHSO constitutes a portion of or a division of a certificated entity, the entity shall file its Annual Report ~~annual report~~ based upon its total operations. In addition, the entity shall file a separate schedule of all financial statements specified in the Annual Report ~~annual report form~~, including the audited financial statement, which covers the PLHSO operation only.

(5) The Annual Report ~~annual report~~ shall include disclosure of material transactions between the PLHSO and a related party. The disclosure shall include:

(a) The nature of the relationship(s) involved.

(b) A description of the transaction, including transactions to which no amounts or nominal amounts were ascribed, for each of the periods for which income statements are presented, and such other information deemed necessary to an understanding of the effects of the transaction on the financial statements.

(c) The dollar amounts of transactions for each of the periods for which income statements are presented and the effects of any change in the method of establishing the terms from that used in the preceding period.

(d) Amounts due from or to related parties as of the date of each balance sheet presented and, if not otherwise apparent, the terms and manner of settlement.

(6) Quarterly reports shall be submitted to the Office within forty-five (45) days following the end of each operating quarter. The initial operating quarter commences after the issuance of a certificate of authority. Quarterly reports shall be submitted in accordance with section 636.043, F.S., on NAIC Quarterly Statement Health Blanks, as adopted in rule 69O-137.001, F.A.C., and shall contain the following supplemental schedules:

(a) A complete identification and dollar value breakdown of all short term investments with individual balances greater than 10% of total short term investments;

(b) A complete list of all debtors with account balances greater than 10% of total prepaid expenses;

(c) An aging analysis on all premium receivables;

(d) A complete aging, identification, and dollar value breakdown of all prepaid expenses with individual balances greater than 10% of total prepaid expenses;

(e) A complete identification and dollar value breakdown of all restricted assets and restricted funds with individual balances greater than 10% of the respective account balance total;

(f) A complete identification and dollar value breakdown of all long term investments with individual balances greater than 10% of total long term investments;

(g) A complete identification and dollar value breakdown of other assets with individual balances greater than 10% of total other assets; and

(h) All surplus notes shall be identified by a complete identification and dollar value breakdown and shall be accompanied by a copy of the surplus note agreement. Each PLHSO is required to submit four (4) quarterly reports in addition to an annual report each fiscal year.

Rulemaking Authority 636.067 FS. Law Implemented 636.009(1)(f), 636.043, 636.058 ~~626.058~~ FS. History—New 11-15-94, Formerly 4-203.070, Amended 9-16-08. Amended_____.

690-203.078 Fees.

Checks ~~for the original application filing or amendments thereto,~~ for filing of each annual report, and for any other fees collected pursuant to these rules or chapter 636, F.S., shall be made payable to the Florida Department of Financial Services. ~~“Chief Financial Officer, State of Florida.”~~

Rulemaking Authority 636.067 FS. Law Implemented 636.057 FS. History—New 11-15-94, Formerly 4-203.078. Amended _____.

690-203.093 Change of Ownership.

~~Change of ownership shall comply with section 628.4615, F.S., and the transaction shall be reviewed and approved by the Office as provided therein. The acquisition application shall be submitted on form OIR-C1-448, which is incorporated by reference in rule 690-203.100, F.A.C.~~

Rulemaking Authority 636.067 FS. Law Implemented 636.065, 628.4615 FS. History—New 11-15-94, Formerly 4-203.093. Repealed, _____.

690-203.100 Prescribed Forms.

The forms listed below are incorporated herein, and made a part of, these rules by reference:

Title	Form Number
(1) Application for Certificate of Authority Prepaid Limited Health Service Organization	OIR-C1-1119 http://www.flrules.org/Gateway/reference.asp?No=Ref 08282 (12/05)
(2) Invoice—Request for Payment of Fingerprint Charges	OIR-C1-903 http://www.flrules.org/Gateway/reference.asp?No=Ref 08290 (12/05)
(3) Biographical Affidavit	OIR-C1-1423 http://www.flrules.org/Gateway/reference.asp?No=Ref 01063 (8/14)
(4) Authority for Release of Information	OIR-C1-450 http://www.flrules.org/Gateway/reference.asp?No=Ref 08301 (5/00)
(5) Service of Process Consent and Agreement	OIR-C1-144 http://www.flrules.org/Gateway/reference.asp?No=Ref 08280 (06/04)
(6) Instructions for Furnishing Background Investigative Reports	OIR-C1-905 http://www.flrules.org/Gateway/reference.asp?No=Ref 08301 (2/15)
(7) Fingerprint Payment and Submission Procedure	OIR-C1-938 http://www.flrules.org/Gateway/reference.asp?No=Ref 08296 (5/13)
(8) Statement of Acquisition merger of Consolidation of a Specialty Insurer Pursuant to Sections 628.461, 628.4615, F.S.	OIR-C1-448 http://www.flrules.org/Gateway/reference.asp?No=Ref 08281 (12/05)
(9) Annual Report Supplement—Contracts Issued and Outstanding	OIR-A2-949 http://www.flrules.org/Gateway/reference.asp?No=Ref 08278 (7/04)
(10) Annual Report Supplement—Damage Claims & Medical Injury	OIR-A2-950 http://www.flrules.org/Gateway/reference.asp?No=Ref 08279 (7/04)

All of the above forms may be obtained from the Office of Insurance Regulation's website: <http://www.flor.com/iportal>.

Rulemaking Authority 636.067 FS. Law Implemented 624.321(1)(a), 624.424, 636.005, 636.008, 636.009, 636.012, 636.043 FS. History—New 11-15-94, Formerly 4-203.100, Amended 7-30-17. Repealed, _____.

690-203.210 Discount Plan Organization Application Forms Incorporated by Reference.

Substantial rewording of Rule 690-203.210, F.A.C. follows. See Florida Administrative Code for present text.

(1) A person applying for a certificate of authority as a discount plan organization shall submit the following:

(a) Form OIR-C1-1606, "Application for License Discount Plan Organization (DPO)," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10323>;

(b) Form OIR-C1-144, "Service of Process Consent & Agreement," effective 6/04, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10326>;

(c) Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10329>;

(d) Form OIR-C1-938, "Fingerprint Payment and Submission Procedures," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10325>;

(e) Form OIR-C1-1423, "Biographical Affidavit," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10324>; and

(f) Form OIR-C1-2221, "Management Information Form," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10327>; and

(2) A person shall submit the forms listed in subsection (1) electronically via the Office's iApply system at <https://www.flair.com/iportal>.

(1) The following forms are hereby incorporated by reference:

(a) Form OIR-C1-1606, Application for License Discount Plan Organization (DPO), effective 01/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10323>;

(b) Form OIR-C1-1423, Biographical Affidavit, effective 03/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10324>;

(c) Form OIR-C1-938, Fingerprint Payment and Submission Procedure, effective 10/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10325>;

(d) Form OIR-C1-144, Service of Process Consent & Agreement, effective 06/04, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10326>;

(e) Form OIR-C1-1298, Management Information Form Complete List of Officers, Directors, and Shareholders (10% or more), effective 03/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10327>; and

(f) OIR-A1-1671, Annual Report Discount Plan Organizations (05/18), available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10328>;

(g) Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, effective 02/15, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10329>.

(2) All of the above referenced forms are available and may be printed from the Office of Insurance Regulation's website: <http://www.flair.com/iportal>.

Rulemaking Authority 624.424(1)(c), 636.232 FS. Law Implemented 624.424, 636.204, 636.218, 636.220, 636.226, 636.228, 636.234, 636.236 FS. History—New 5-22-05, Amended 10-29-08, 7-30-17, 4-11-19. Amended _____.

690-203.215 Annual Reports.

Annual Reports are to be filed with the Office within three months after the end of each fiscal year on Form OIR-A1-1671, "Annual Report – Discount Plan Organizations," effective 5/18, hereby incorporated by reference and available at www.flrules.org/XXXXX. The filings shall be submitted electronically via the Office's system at <https://www.flair.com/iportal>.

Rulemaking Authority 638.218(2), 636.232 FS. Law Implemented 636.218 FS. History—New _____.



**Office of Insurance Regulation
Life & Health Financial Oversight**

FLORIDA

COMPANY CODE:

FEDERAL EMPLOYER

IDENTIFICATION NUMBER

_____ -- _____

ANNUAL REPORT

OF THE

NAME OF THE DISCOUNT PLAN ORGANIZATION (DPO)

(CITY)

(STATE)

TO THE

OFFICE OF INSURANCE REGULATION

OF THE

STATE OF FLORIDA

Life & Health Financial Oversight
200 East Gaines Street
Tallahassee, FL 32399 - 0327

FOR THE FISCAL YEAR ENDED

DUE ON OR BEFORE

3 MONTHS AFTER THE END OF EACH FISCAL YEAR END

REPORT MUST BE TYPED OR PRINTED

Name of Discount Plan Organization (DPO):

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

Federal Employer Identification Number (FEIN)	_ _ _ _ _ -- _ _ _ _ _		
Complete address of DPO's principal office			
Full name & title of DPO's chief executive officer			
Web Site (s. 636.204 (4))			
Type of entity (check one)	☐ Corporation - For profit ☐ Corporation - Not-for-profit ☐ Partnership ☐ Sole proprietorship ☐ Limited liability company ☐ Other:		
This annual report shall be signed below by two corporate officers of the DPO, if the DPO is a corporation; the DPO's partners, if the DPO is a partnership; the DPO's owner, if the DPO is a sole proprietorship; or the DPO's managing or other duly authorized member, if the DPO is a limited liability company.			
Printed name		Printed name	
Title		Title	
Signature		Signature	

Instructions

1. Within 3 months after the end of each fiscal year, complete and file this report for the preceding fiscal year with:

The Office of Insurance Regulation
Life & Health Financial Oversight
200 E. Gaines Street
Tallahassee, Florida 32399-0327

2. Provide all requested information on page 2. Have the report signed on page 2 consistent with the instructions thereon.
3. Answer questions a through r on pages 4 and 5, as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses, clearly identifying each attachment and the question number being answered.
4. Attach a copy of the audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding fiscal year.

An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity. The Office may accept this petition if all of the following are met:

- The licensee is 100% owned by the parent directly or indirectly
 - The parent receives an unqualified opinion
 - The parent's audited financial statement reflects at least a \$5 million net worth on a GAAP basis
 - The parent provides a parental guarantee The licensee provides un-audited financial statement on a GAAP basis attested to which reflects a surplus of \$150,000 or more.
 - Licensee requests petition in writing at least 30 days prior to due date of annual report
5. If different from the initial application or the last annual report, complete the schedule on page 7, and include the complete names, address, or Federal taxpayer identifying numbers, titles, and ownership percentages of all officers, directors, managing members, and 10% or greater owners, and for each indicate whether that individual is an officer, director, and/or owner. Please disclose the extent and nature of any contracts or arrangements between such persons and the DPO, including any possible conflicts of interest. Attach additional pages as needed.

Name of Discount Plan Organization (DPO):

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

6. For each individual who, during the period covered by this report, was a member of the DPO's Board of Directors, Board of Trustees, Executive Committee, or other governing board or committee, or who was one of its principal officers or managing members, responsible for the conduct of its affairs, or in a position to exercise control or influence over its affairs, **and for whom the DPO has not previously done so**, (1) make arrangements to have an investigation report forwarded directly to the Office, and (2) attach to this report: (a) a statement informing the Office of the date that such investigative report was requested, (b) completed NAIC Biographical Statement and Affidavit, and (c) two completed Florida fingerprint cards. Only Florida fingerprint cards will be accepted. Florida fingerprint cards may be obtained by calling the Office of Insurance Regulation, L&H Financial Oversight, at (850) 413-5052.

7. As stated in s.636.204(3), "The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of \$50 and if the office is satisfied that the licensee is in compliance with this part." Attach evidence of your \$50 renewal fee being paid to the Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100. Page 8 of this report should be detached and mailed to the address given, along with your check for \$50, **prior to the anniversary date of the DPO obtaining its license.**

8. Answer the questions below as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses.

		Yes	No
a	Have there been any changes to any of the DPO's basic organizational documents, such as its bylaws or articles of incorporation? If so, attach an explanation of all such changes, and copies of the amended documents.		
b	Have there been any changes in the DPO's ownership? If so, attach a statement containing complete details, and an organizational chart depicting all direct and indirect relationships between the DPO and all of its affiliates, including the ultimate parent corporation of all such entities.		
c	Was the DPO a party to any civil or criminal legal action, other than as plaintiff in a civil matter? If so, attach a statement containing complete details.		
d	Is the DPO doing business in any state(s) other than Florida? If so, attach a schedule of all such state(s).		
e	Was the DPO's license, registration, or certificate of authority to act as a DPO suspended or revoked by any governmental agency, or did any governmental agency initiate formal legal proceedings for said purpose? If so, attach a statement containing complete details.		
f	Has any governmental entity imposed fines or costs, other than normal filing fees or renewal fees, for activities arising from DPO operations? If yes, attach a statement containing complete details.		

Name of Discount Plan Organization (DPO):

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

g	Has the DPO either maintained a surety bond in its own name, or securities eligible for deposit with Collateral Management, in an amount not less than \$35,000?		
h	Are all advertisements, marketing materials, brochures, and discount cards used by marketers approved in writing for such use by the DPO?		
i	Does the DPO have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the DPO?		
j	Is the DPO monitoring the content of all its websites for compliance with s.636.210, s.636.212, and s.636.226 Florida Statutes?		
k	Did the DPO fail to pay any judgment rendered, if any, against it in any state within 60 days after the judgment became final? If so, attach a statement containing complete details.		
l	Was the DPO at any time unable to fully pay when due any debts, or to timely meet any other obligations: If so, attach a statement containing complete details.		
m	Was the DPO or any of its owners, officers, or directors, convicted of, or did it (or that person) enter a plea of guilty or nolo contendere to a felony in any state without regard to whether adjudication was withheld? If so, attach a statement containing complete details.		

		Florida
n	For the year covered by this report, what was the total amount of revenue collected for Florida DPO business?	\$
o	How many residents of Florida are members of the DPO?	
p	List the internet websites used by the DPO and its marketers.	

Name of Discount Plan Organization (DPO):

Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____

CHECK LIST

Please indicate by checking the boxes that each action has been taken

- ☐ This Report has been completed in its entirety with all schedules.
- ☐ Audited CPA financial statements and Opinion Letter are attached.
- ☐ Separate responses, cross-referenced to the question, are attached where appropriate.
- ☐ All financial statements and schedules are mathematically correct.
- ☐ If required, biographical statements, background investigative reports, and fingerprint cards
- ☐ Evidence of payment of license renewal fee.
- ☐ Requests for clarification may be sent electronically to the e-mail address below.

The person to contact regarding any information contained in this report is:

(name & position / title)

(address)

(city, state, zip)

(____ ____ ____) ____ ____ ____ - ____ ____ ____ EXT: ____ ____ ____
(area code - telephone number - extension)

(____ ____ ____) ____ ____ ____ - ____ ____ ____
(area code - fax number)

(e-mail, if applicable)

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

MANAGEMENT / OWNERS INFORMATION

Provide the requested information for all new Officers, Directors, or Other Individuals Responsible for the Operations of the Licensee; include percentage of ownership in the % column. Also, provide the requested information for all new Owners (Members of the Licensee's Organization) with an interest of 10% or greater. If the new Owner is a company, partnership, or other organization, enter the requested information on the last line.

(See instruction 6 on page 3.)

[illegible]

(If additional space is needed attach a separate sheet to this Schedule.)

For each of the individuals listed above, has the information required by item 5 of the instructions been included? _____

For each of the individuals listed above, are the attachments required by item 6 of the instructions been included? _____

Have all new officers, directors, and owners been revealed? _____

The following Officers and Directors are no longer associated with the DPO: _____

The following, previously reported as having an ownership interest in the DPO, no longer have an ownership interest:



Office of Insurance Regulation
Life & Health Financial Oversight

REMITTANCE FORM

Detach and separately forward this page prior to the due date of the required license renewal with your payment to the address below.

Name of Discount Plan Organization	
Street address	
City, State, Zip	
Federal Employer Identification Number	__ __ -- __ __ __ __ __ __ __ __
Florida Company Code	__ __ __ __ __
Renewal Date of License	_____ 20 __ __

ATTACH CHECK FOR \$50.00 HERE.

MAKE CHECK PAYABLE TO
DEPARTMENT OF FINANCIAL SERVICES

MAIL PAYMENT & THIS PAGE TO:

DEPARTMENT OF FINANCIAL SERVICES
REVENUE PROCESSING SECTION
P. O. BOX 6100
TALLAHASSEE, FLORIDA 32314-6100

FOR OFFICE OF INSURANCE REGULATION USE ONLY

AMOUNT	TYPE/CLASS	FEE	FUND ACCOUNT
\$50.00	1300	L	Renewal License Fee



Florida Office of Insurance Regulation

**ANNUAL REPORT
CONTRACTS ISSUED
& OUTSTANDING**

**MANAGED
CARE
COMPANY:** _____

YEAR ENDING: _____

**Number of health contracts issued and outstanding and number terminated.
[HMOs-641.26(1)(d), F.S.; PHCs-641.41(1)(c), F.S.; PLHSOs-636.043(2)(c), F.S.]**

Group subscriber contracts issued and outstanding

Individual subscriber contracts issued and outstanding

Group subscriber contracts terminated

Individual subscriber contracts terminated



Florida Office of Insurance Regulation

ANNUAL REPORT

**DAMAGE CLAIMS &
MEDICAL INJURY**

MANAGED

CARE

COMPANY:

YEAR ENDING:

The number and amount of damage claims for medical injury initiated against the health entity and any providers engaged by it during the reporting year.

[HMOs-641.26(1)(e), F.S.; PHCs-641.41(1)(e); PLHSOs 636.043(2)(d)]

Number of Claims

Total Dollar Value of Claims

Number of Claims Without Legal Process

Number of Claims Disposed (Settled, or Otherwise Discharged)

SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

☐ Original Designation ☐ Insurer Name Change ☐ Merger / Acquisition ☐ Update Delivery Information

Insurer or Company Name: _____

Previous Name (If applicable): _____

Home Office Address: _____

City, State, Zip _____

FEI# FL Company Code Telephone#

Know all men by these present, that the insurer or other entity named above is subject to the statutory agent for service of process provisions of the Florida Insurance Code duly organized and existing under and by virtue of the laws of the state of domicile.

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in any county in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof.

The undersigned hereby further agrees and stipulates that this agreement is and shall remain irrevocable, so long as there is liability, under any policy, claim or cause of action within this state, either fixed or contingent. Said insurer or other entity does hereby designate the following as the name and address of the person to whom all process is to be forwarded when process is served upon said Chief Financial Officer of the State of Florida on behalf of the above named insurer or entity, **In the event of a change in the name of the insurer or the designation of the person to whom process is to be forwarded, whether it be name, address, and/or phone or fax numbers, the insurer or company shall immediately file a new agreement form with the Chief Financial Officer of the State of Florida at the address shown at the bottom of this page.**

**Designated Person
to receive process:** _____

E-Mail Address: _____

Phone#: _____ **Fax#** _____

Mailing Address: _____

Street Address: _____

Signature:

I hereby consent and agree to be the person to whom process served upon
the Chief Financial Officer of the State of Florida for said entity, may be forwarded.

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of said insurer or other entity, being duly authorized by the Board of Directors or governing body of this entity to execute this document, have hereunto set our hands and affixed the seal of said insurer or other entity on this the _____ day of _____, AD. _____.

SEAL

President or CEO's Signature

President or CEO's Name (Typed or Printed)

Secretary's Signature

Secretary's Name (Typed or Printed)

Any signatures other than the President, CEO, or Secretary for the Company must be validated by the attachment of a resolution of the Board of Directors or Governing body of said company delegating the authority to sign for the company.

690-203.210
690-191.107
OIR-C1-144
Rev 06/2004

Service of Process Section

200 East Gaines Street • PO Box 6200 • Tallahassee, FL 32314-6200 • (850) 413-4200 • Fax (850) 922-2544



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail **ONLY** completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.

OIR-C1-938

Rev: 6/20

Rule 69O-203.020, 69O-203.210



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL



Office of Insurance Regulation
Company Admissions

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

This package is designed to assist individuals in preparing the application with all the information required by statute and facilitate expeditious processing of the application by the Office. This package includes five (5) categories of information:

Section I	Application Fees and Form
Section II	Legal
Section III	Financial and Related Information
Section IV	Management
Section V	Forms and Rates

It is extremely important that the application be completed in its entirety in the format specified.

Please submit your package in a binder that has been two-hole punched at the top and place tabs at the bottom of the documents. (Example: the tab labeled II-1 would contain the certified Articles of Incorporation and all amendments).

THE COMPLETED CHECKLIST MUST BE RETURNED WITH THE APPLICATION PACKAGE!

It is recommended that, prior to filing the application, you schedule a pre-filing conference with the Managed Care Section to review any particular problems that our Office has encountered in the past. Although the pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office. To schedule a conference, please call (850) 413-2570.

Once the application is complete, mail it to:

Florida Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Larson Building
Tallahassee, Florida 32399-0332

**IN ORDER FOR A SUBMISSION TO BE CONSIDERED A COMPLETE APPLICATION,
ALL REQUIRED INFORMATION MUST BE INCLUDED IN THE FILING. FILINGS
THAT DO NOT INCLUDE ALL REQUIRED INFORMATION WILL BE DISAPPROVED
OR RETURNED.**

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

**INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM**

Section I-1 Application Fees

Applicants must pay a filing fee of \$500.00. The fee is due and payable at the time of filing the application for licensure.

Secure your check to the INVOICE (included in this package) and send to:

Florida Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

Place a copy of the INVOICE and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-3. The fingerprint cards along with the fees are due at the time the application is filed. A set of instructions for completing the fingerprint cards is included with this package.

Secure your check to the INVOICE (included in this package) and send to:

Florida Department of Financial Services
Bureau of Financial Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

Place a copy of the INVOICE and a copy of the check along with the fingerprint cards in Section (I-2) of the application. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-3 Application for Certificate of Authority (Official Form)

On this form, list the lines of business by code (see enclosed classifications and code number form) that you intend to write in the State of Florida. **THE COMPANY MUST BE AUTHORIZED IN ITS STATE OF DOMICILE FOR THE LINES OF BUSINESS THAT ARE BEING REQUESTED.** When a Certificate of Authority is issued by the Office of Insurance Regulation, it will include only those lines listed on this form and addressed in the proformas in the Plan of Operations. This form must be under corporate seal and signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the Company.

Form OIR-C1-1119
Rev 6/20
Rule 69O-203.020

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Include in this section, the applicant's Articles of Incorporation and all amendments. These documents must be certified by the Florida Secretary of State. The certificate must be an original obtained from the Florida Secretary of State's office no earlier than six months prior to the date the application is filed. **SUBMIT AN ORIGINAL AND ONE COPY.**

Section II-2 Certificate of Status from Florida Secretary of State

Provide a Certificate of Status. This is a document issued by the Florida Secretary of State. The document certifies that the corporation is duly organized in this State and that all state taxes and fees have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s. 636.005, F.S.]

If you have any questions concerning filing with the Secretary of State, please contact their Division of Corporations at (850) 245-6051.

Important note: The Secretary of State will issue a charter to a prepaid limited health service organization before the Office of Insurance Regulation completes its processing of an application for a certificate of authority. This charter authorizes the company to engage in any type of business except insurance. **Your company MAY NOT engage in the business of a prepaid limited health service organization in Florida until it has been issued a Certificate of Authority by the Director of Insurance Regulation.**

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include two sets of the corporation's By-Laws, Constitution, and/or Rules and Regulations in this section. These documents must be accompanied by a Board Resolution signed and dated by the Secretary of the corporation, stating that the documents are a true and correct copy. **NO** other signatures will be accepted other than the Secretary's signature. **SUBMIT AN ORIGINAL AND ONE COPY.**

Section II-4 Certificate of Compliance (Foreign Applicants Only)

Provide a Certificate of Compliance. A Certificate of Compliance is a document issued by the public official having supervision of insurance in applicant's state of domicile showing that the company is duly organized and authorized to issue prepaid limited health service contracts therein and the kinds of contracts it is so authorized to transact. The certificate should be an original under seal by the insurer's state of domicile.

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, advertising media to be used, and contact representatives to be used. Also, submit a detailed marketing budget which reflects the proposed method of marketing for a three-year period. Include such items as compensation, local and out-of-town travel, equipment, printing and postage, advertising and public relations, expense accounts, meeting costs, and any applicable publications.

Section III-2 Advertising

Submit a full disclosure of the PLHSO's proposed advertising. All advertisements shall be available in English and shall include all printed and published material, descriptive literature and sales aids, sales talks and sales material, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television, or direct mail. The full name and address of the PLHSO must be clearly contained in all advertisements. Each piece of advertising shall have a unique number or designation which will readily identify it from all other advertising.

Section III-3 Marketing Personnel

Submit a list of licensed health agents to be used initially in soliciting contracts or procuring applications.

Section III-4 Insurance

- A. Furnish evidence of adequate insurance coverage (copy of insurance policy) or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of limited health services.
 - (1) General liability.
 - (2) Medical malpractice or professional liability.
- B. Furnish evidence that a blanket fidelity bond in the amount of at least \$50,000. has been obtained (copy of bond). All employees handling the funds must be covered by the blanket fidelity bond. In lieu of the bond, the applicant may deposit with the Office cash or securities or other investments of the types set forth in section 636.042, Florida Statutes.

Section III-5 Financial

- A. A copy of the applicant's most recent financial statements audited by an independent certified public accountant.
- B. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed. Financial projections shall include:
 - (1) A balance sheet.
 - (2) An income statement.
 - (3) A cash flow analysis.
 - (4) A change in financial position.
- C. A description of how the applicant will comply with Section 636.046, Florida Statutes.
 - (1) Each PLHSO shall deposit with the Office cash or securities of the type eligible under Section 625.52, F.S., which shall have at all times a market value of \$50,000.
 - (2) If for any reason the market value of assets and securities of a PLHSO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.
- D. **Each PLHSO shall at all times maintain a minimum surplus in an amount which is the greater of \$150,000 or 10% of total liabilities.**
- E. Evidence that the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. This should include:
 - (1) Statement of the financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, co-payments, and other patient charges used in connection therewith.
 - (2) The adequacy of surplus, other sources of funding, and provisions for contingencies.
- F. Furnish a statement from a qualified independent actuary that the entity is actuarially sound.

Section III-6 Contractual

- A. A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees. Include a copy of each type of contract, with a signature page from each executed contract.
- B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees.
- C. Copies of all relevant business leases, including rental of real property, equipment, etc. Include the anticipated cost for the life of the lease. If there are no business leases, please so indicate.

Section III-7 Enrollment

Describe the following assumptions underlying enrollment projections:

- A. A monthly projection of enrollment for a three-year period.
- B. Number of eligibles residing within the service area.
- C. Contract size assumptions (contract distribution and content).
- D. Penetration assumptions and rationale, including initial enrollments and renewals.
- E. Allowance for voluntary/involuntary disenrollment and group contract additions during the year.
- F. Date of break even (month, year) based on number of enrollments.

Section III-8 Certificate of Deposit (Foreign Insurers Only)

A Certificate of Deposit is a document issued by the public official having supervision of insurance in the applicant's state of domicile showing the amount and the composition of the deposit maintained by the insurer in another state. The certificate must be an original, sealed by the insurer's state or country of domicile.

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION
SECTION IV - MANAGEMENT**

ALL NAMES PROVIDED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES (no abbreviations).

Section IV-1 A list of the names (alphabetically), addresses, and official positions of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant. Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the PLHSO, including any possible conflicts of interest.

Section IV-2 A list of the owners of the PLHSO, including the extent of the ownership interest of each person or entity and an organizational chart depicting all levels of ownership, including all subsidiaries and parent organizations along with all affiliated companies and corresponding percentages of ownership.

Section IV-3 Biographical Statement and Affidavits, are to be submitted for all officers, directors, managers, and administrators of the PLHSO and all persons controlling and/or owning 10% or more of the ownership interest of the PLHSO. Be sure to include the management positions such as the executive director, medical director, finance director, and marketing director.

A Biographical Statement and Affidavit form (Office of Insurance Regulation Official Form Only) is included in this application package for you to duplicate and use in order to complete this section. All questions must be answered and all "yes" answers must be accompanied by an explanation. Each Biographical Statement and Affidavit must contain an original signature of the principal and an original notary seal. **Please file an original in the order of the list from Section IV-1. Do not retype the DOI Official Biographical Statement and Affidavit form. Retyped forms will not be accepted.**

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.0721(8), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-4 An Authority for Release of Information Form must be completed for each person listed in Section IV-3. Each Authority for Release form must contain an original signature of the principal and an original notary seal. **Please file an original of each Authority for Release of Information form in the order of the list provided in Section IV-1.**

Section IV-5 An Investigative Background Report must be provided for each person listed in Section IV-3. These reports must be mailed directly to the Office from the reporting entity. Because the reports are to be paid for by the applicant, please arrange for the billing to be sent by the investigative reporting firm to your accounting office. Instructions for providing these reports are enclosed. If using another reporting entity, please contact that company for instructions.

Evidence indicating that the reports have been ordered for all officers, directors, and trustees must be submitted by the applicant. Acceptable evidence includes a copy of the cancelled check issued to the investigative firm in payment for the reports and a copy of the letter of transmittal to the investigative firm with proof of mailing. The evidence should be dated no less than four (4) weeks prior to the date of the application.

Section IV-6 Fingerprint cards must be completed for each person listed in Section IV-3. The fingerprint cards along with the fees are due at the time the application is filed. **No cards other than those furnished by the Office will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. A set of instructions for completing the fingerprint cards is included with this package.

PLEASE NOTE: Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

Section IV-7 A statement generally describing the applicant, its facilities and personnel, and the limited health service to be offered.

Section IV-8 A description of the subscriber complaint procedures to be established and maintained as required under Section 636.038, Florida Statutes.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION
SECTION V - FORMS AND RATES**

NOTE: THE COMPANY IS CAUTIONED NOT TO WRITE BUSINESS USING UNAPPROVED FORMS OR RATES.

Section V-1 Forms

- A. Submit three copies of the policy, contract, certificate of coverage, member handbook, application, or any other form the applicant proposes to offer the subscriber. This includes any form showing the benefits to which the subscriber is entitled and any form used in the enrollment process. Every form which the PLHSO will use in connection with its subscriber contracts must be submitted and must be identified by a unique form number located on the lower left corner of the form.
- B. Each subscriber contract must state the procedures for offering limited health services and offering and terminating contracts to subscribers which will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status.

Section V-2 Rates

Submit three copies of the complete schedule of proposed premium rates for each type of contract. The submission for each separate contract should contain an opinion from a qualified independent actuary or a qualified employee. The opinion shall:

- (1) Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
- (2) Certify that the rates are appropriate for the classes or risks for which they have been computed; and
- (3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

**CHECK LIST
SECTION I - APPLICATION FEES AND FORM**

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Insurer application fees paid	☐
(a) Copy of invoice included (Official Form).....	☐
(b) Copy of check	☐
(c) Placed in Section I	☐
(d) Originals mailed to Bureau of Financial Services.....	☐
2. Fingerprint fees paid.....	☐
(a) Copy of invoice included	☐
(b) Copy of check	☐
3. Application for Certificate of Authority (Official Form)	☐
(a) All blanks completed	☐
(b) Sealed by corporation	☐
(c) Signed by President or other authorized officer (original signature)	☐
(d) Lines of business listed by codes	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION II - LEGAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Articles of Incorporation and all amendments.....	☐
(a) Original certification by Florida Secretary of State	☐
(b) Articles with all amendments attached	☐
(c) Original and one copy	☐
2. Certificate of Status from Florida Secretary of State (original document)	☐
(a) Good standing indicated	☐
(b) Sealed by state	☐
(c) Signed by proper public official	☐
(d) Original and one copy	☐
2. Corporate By-Laws, Rules and Regulations, and/or Constitution	☐
(a) Signed and dated by corporation secretary	☐
(b) Sealed by corporation	☐
(c) Original and one copy	☐
(d) Board Resolution	☐

Section II - Legal
Required Filing and Check List

<u>Item #</u>	<u>Completion Check List</u>
4. Certificate of Compliance From State or County of domicile	☐
(a) Original Certification from State of domicile	☐
(b) Form indicates lines of business the company is authorized to transact	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Marketing and growth	☐
(a) Description of marketing methods	☐
(b) A detailed marketing budget	☐
(c) List of persons employed to solicit contracts or procure applications.....	☐
2. Advertising.....	☐
(a) Include all printed and published material	☐
(b) Sales talks, radio, TV, etc.	☐
(c) Full name and address clearly shown	☐
(d) Unique number or designation on each form.	☐
3. Marketing personnel.....	☐
(a) Submit a list of agents to be used initially.....	☐
4. Insurance	☐
(a) Current general liability policy or plan for self-insurance.	☐
(b) Current medical malpractice policy or plan for self-insurance	☐

Section III - Financial and Related Information
Required Filing and Check List

Item #	Completion Check List
5. Financial	☐
A. Current audited financial statements	☐
B. Financial plan and 3 yr. projections	☐
Anticipated operating results.....	☐
Statement of sources of funding	☐
Provisions for contingencies	☐
(1) A balance sheet.....	☐
(2) An income statement.....	☐
(3) A cash flow analysis	☐
(4) A change in financial position	☐
C. Evidence of compliance with Section III-5C 1&2.....	☐
D. Compliance with minimum surplus requirement	☐
E. Statement of soundness of the PLHSO	☐
6. Contractual Documents	☐
(a) Provider contract form and signature pages	☐
(b) Other forms of contracts	☐
(c) All relevant business leases	☐
7. Complete enrollment information.....	☐
(a) Sections A through F addressed	☐

Section III - Financial and Related Information
Required Filing and Check List

Item #	Completion Check List
8. Certificate of Deposit	☐
(a) Original document provided	☐
(b) Original seal affixed by state of domicile	☐

**APPLICATION FOR CERTIFICATION OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION IV - MANAGEMENT

Company Name: _____

Item #	Completion Check List
1. Alphabetical listing of officers, directors, trustees, etc.....	☐
(a) Separate listing of all officers and directors for the corporation	☐
(b) Separate listing of trustees and others	☐
(c) Full names listed	☐
(d) Titles listed	☐
2. A list of the owners of the PLHSO	☐
(a) Extent of ownership interest of each person or entity	☐
(b) Organizational chart showing all levels of ownership.....	☐
3. Biographical affidavits for each individual listed in Section IV-3 (Official Form).....	☐
For each biographical affidavit	
(a) All blanks completed	☐
(b) "Yes" answers explained	☐
(c) Contains original signature	☐
(d) Notarized (original).....	☐
(e) Submitted original of each affidavit.....	☐

Section IV - Management
Required Filing and Check List

Item #	Completion Check List
4. Authority for Release of Information Forms for each individual listed in Section IV-3 (Official Form)	☐
(a) Release form contains original signature	☐
(b) Each release form is Notarized (original)	☐
(c) Submitted original of each release form	☐
5. Investigative Background Report for each individual listed in Section IV-3	☐
(a) Investigative reporting firm contacted	☐
(b) Full names given to investigative reporting firm for all individuals listed in Section IV-3	☐
(c) Arrangements made for reports to be sent directly to this Office.....	☐
(d) Evidence indicating report has been ordered for all officers, directors and trustees, dated no less than 4 weeks prior to date of application (cancelled check or letter of transmittal).....	☐
6. Fingerprint cards enclosed for each person listed Section IV-3.....	☐
(a) Contains original signature	☐
(b) Card furnished by Office of Insurance Regulation.....	☐
(c) No erasures or alterations on cards	☐
(d) All blanks filled in.....	☐

**Section IV - Management
Required Filing and Check List**

Item #	Completion Check List
7. A statement describing the applicant, facilities and personnel, and service to be offered	☐
8. Description of subscriber complaint procedures.....	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION V - FORMS AND RATES

Company Name: _____

Item #	Completion Check List
1. Forms	☐
(a) 3 copies of each.....	☐
(b) Identified by unique form number	☐
2. Rates	☐
(a) 3 copies of each filing	☐
(b) Opinion from qualified actuary or employee.....	☐
(c) Statement of actuarial soundness	☐

**APPLICATION FOR CERTIFICATE OF AUTHORITY FORM
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

Pursuant to Chapter 636, Florida Statutes, application is hereby submitted to form and operate a Prepaid Limited Health Service Organization.

Proposed name of Prepaid Limited Health Service Organization:

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

In order to qualify as a Prepaid Limited Health Service Organization (PLHSO), an entity shall:

- (1) Provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. This **MAY** include ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services **OR** pharmaceutical services.

NOTE: Limited health services shall not include inpatient, hospital surgical services, or emergency services, except as such services are provided incident to the limited health services.

- (2) Provide, either directly or through arrangement with other persons, limited health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed sum basis; and
- (3) Provide, either directly or through arrangements with other persons, limited health care services to subscribers through a closed panel of providers.

APPLICATION CERTIFICATION

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to apply to operate as a _____ in this state; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

(Corporate Seal)

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20__, by _____
(name of person)

as _____ for _____.

(type of authority; e.g., officer, trustee, attorney in fact)

(company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**Application for Certificate of Authority
Prepaid Limited Health Services Organizations
Lines of Business Codes**

Lines of Business	Code Numbers
Dental Care Services	451
Ambulance Services	700
Vision Care Services	712
Pharmaceutical Service	716
Mental Health Service	781
Substance Abuse Services	782
Chiropractic Services	783
Podiatric Care Services	784

INVOICE
REQUEST FOR PAYMENT OF APPLICATION
FEES

NAME OF PREPAID LIMITED HEALTH SERVICE ORGANIZATION: _____

FEIN# _____

ADDRESS: _____

CITY, STATE & ZIP CODE : _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

(CITY) (STATE) (ZIP CODE)

In reference to the submission of the above-referenced insurer's application to do business in Florida, it is necessary for this form to be returned with proper payment.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail the check and invoice only to the Florida Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and a copy of the invoice with the completed application package that is submitted to the Office of Insurance Regulation, Company Admissions, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

For Accounting Use Only

<u>BIT</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
C	10/36	L	\$500.00

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: _____ Middle: _____ Last: _____

2. a. Are you a citizen of the United States?

Yes ☐ No ☐

b. Are you a citizen of any other country?

Yes ☐ No ☐

If yes, what country? _____

3. Affiant's occupation or profession: _____

4. Affiant's business address: _____

Business telephone: _____ Business Email: _____

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Present or proposed position with the Applicant Company: _____

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending

Dates (MM/YY): _____ - _____ Employer's Name: _____

Address: _____ City: _____ State/Province: _____

Country: _____ Postal Code: _____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐ No ☐

If any claims were made on the bond, give details: _____

- b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐ No ☐

If yes, give details: _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

- a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes ☐ No ☐

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

- b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
- Yes ☐ No ☐
- c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
- Yes ☐ No ☐
- d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
- Yes ☐ No ☐
- g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
- Yes ☐ No ☐
- h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
- Yes ☐ No ☐
- i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
- Yes ☐ No ☐
- j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
- Yes ☐ No ☐

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person,

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details. _____

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☐

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details: _____

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☐

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☐

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Yes ☐ No ☐

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

____ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

**BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information**

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____

IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☐

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

4. Government Identification Number if not a U.S. Citizen: _____

5. Foreign Student ID# (if applicable) : _____

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. Date of Birth: (MM/DD/YY) : _____ Place of Birth, City: _____
State/Province: _____ Country: _____

7. Name of Affiant's Spouse (if applicable) : _____

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

___ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[company name]** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[name of CRA, address]** (“CRA”). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency (“CRA”) by submitting a written request to Company. You should submit any such written request for more information, to _____ **[company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.” You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: _____ County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, 20____ by _____, and:

- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.



Office of Insurance Regulation
Company Admissions

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

The Office receives applications electronically. Please submit your application at <http://www.floir.com/iportal>, using the iApply link to Online Company Admissions.

This package is designed to assist individuals in preparing the application with all the information required by statute and to facilitate expeditious processing of the application by this Office.

PLEASE NOTE: THE COMPLETED CHECK LIST MUST BE SUBMITTED WITH THE APPLICATION PACKAGE.

The completed application package must be submitted to the Office by utilizing the following link:

<http://www.floir.com/iportal>
and select iApply – Online Company Admissions

If this package requires submission of forms and/or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal <http://www.floir.com/iportal> and select “Form & Rate Filing Assembly and Submission” to begin the submission of forms and/or rates.

If this package requires original documents, in lieu of providing original paper documents, the Applicant is directed to submit a PDF of the original document(s) unless otherwise required by Florida Statutes.

Any questions concerning this application package may be directed to the Application Coordinator at appcoord@floir.com. For iApply only questions, contact the Application Coordinator at iapply@floir.com

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

Pursuant to Section 636.Part II, Florida Statutes, in order to do business as a Discount Plan Organization (DPO), an entity must:

- A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, Part I of Chapter 607, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S.
[s., 636.204(1), F.S.];
- B. Be an entity, which in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM**

Section I-1 Application Fee

The application filing fee is \$50.00. The initial fee is due and payable at the time of filing the application for licensure. [s.636.204(2)(l) and s.636.204(5), F.S.]

Secure the check to the invoice, which is included in this package, and send to:

Florida Department of Financial Services
Revenue Processing Section
P.O. Box 6100
Tallahassee, Florida 32314-6100

Submit a copy of the invoice and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Processing Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938 for instructions.

Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see form OIR-C1-938 for instructions.

Section I-3 Application for License (Official Form included with this package)

This form must be sworn to by an officer or authorized representative of the applicant.

SECTION II-LEGAL

Section II-1 Articles of Incorporation

Include in this section the applicant's Articles of Incorporation or other organizing documents, including all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original. [s.636.204(2)(a), F.S.]

Section II-2 Certificate of Status from Florida Secretary of State

Provide a Certificate of Status document issued by the Florida Secretary of State which certifies that the applicant is authorized in this State and that all state taxes and fees

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s.636.204(1), F.S.]

If you have any questions concerning filing with the Secretary of State, please contact the Division of Corporations at (850) 245-6051 or see <http://www.sunbiz.org/>.

Important note: The Secretary of State will issue a charter to a discount plan organization before the Office completes its processing of an application for a license. This charter authorizes the company to engage in any type of business except insurance or discount plans, or other regulated business.

Your company MAY NOT engage in the business of a discount plan in Florida until it has been issued a license by the Commissioner of the Office.

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include a copy of the applicant's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be signed, and recently dated by the Secretary of the company. No signature other than the Secretary's will be accepted. [s. 636.204(2)(b), F.S.]

Section II-4 Certificate of Compliance (Foreign Applicants Only)

If applicable, provide a Certificate of Compliance issued by the public official having supervision in applicant's state of domicile showing that the company is organized and authorized to issue contracts and the kinds of contracts it is authorized to transact. The certificate should be an original under seal by the organization's state of domicile. If not applicable, please state this in the application.

Section II-5 Service of Process Form

[s.636.234, 624.422 and 624.423 F.S.]

Provide an executed Service of Process Consent and Agreement form (official form included in this package) under corporate seal and signed by the president or chief executive officer and secretary.

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of discounts to be offered, and advertising media to be used.
[s. 636.204(2)(j), F.S.]

Section III-2 Advertising

Provide a description of the procedures in place for the DPO to approve advertising, prior to use, pursuant to Section 636.228, Florida Statutes.

Section III-3 Website

Prior to licensure by the Office, each DPO must establish an Internet website that conforms to the requirements of Section 636.226, Florida Statutes. [s. 636.204(4)] This website should also comply with the disclosures required in s. 636.212, F.S. and should not include any prohibitions listed in s. 636.210, F.S.

Provide the address of the website that complies with these statutes.

Section III-4 Financial

A. Submit a copy of the applicant's most recent financial statements audited by an independent certified public accountant [s.636.204,(2)(i), F.S.], and provide the date of the company's fiscal year end.

B. Each DPO must at all times maintain a net worth of at least \$150,000.
[s.636.220(1), F.S.]

The OFFICE may not issue a license unless the DPO has a net worth of at least \$150,000.
[s.636.220(2), F.S.]

C. Documentation that the applicant has complied with the surety bond or security deposit requirements [636.236(1), Florida Statutes]. For security deposits, contact the Bureau of Collateral Management at (850) 413-3167.

(1) Each DPO must maintain in force (unless deposit is placed in lieu of the bond) a surety bond in its own name in an amount not less than \$35,000 to be used at the discretion of the Office to protect the financial interest of members who may be adversely affected by the insolvency of a DPO. The bond must be issued by an insurance company that is licensed to do business in this state.

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

- (2) In lieu of #1 above, each DPO shall deposit with the Bureau of Collateral Management cash or securities of the type eligible under Section 625.52, Florida Statutes, which shall have at all times a market value of \$35,000.
- (3) If for any reason the market value of assets and securities of DPO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.

Section III-5 Contractual

- A. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members. [s. 636.204(2)(f), F.S.]
- B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members. [s. 636.204(2)(h), F. S.]
- C. A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in the Management Section (Section IV) of this application as individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10% or more voting securities of the applicant. [s. 636.204(2)(c) and (g), F.S.]

Section III-6 A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered. [s. 636.204(2)(e), F.S.]

Section III-7 A description of the subscriber complaint procedures to be established and maintained. [s. 636.204,(2)(k), F.S.]

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION IV - MANAGEMENT

NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES.

Section IV-1 List of All Officers, Directors, and Shareholders [s.636.204(2)(c) F.S.]

- A. List the names, addresses and official positions of each officer, director and any person having direct or indirect control of the organization, including but not limited to contracted management company personnel (form included in this package).
- B. List the names of each shareholder owning ten percent or more of voting securities of the applicant or any person having the right to acquire ten percent or more of the voting securities of the applicant (issued and outstanding warrants/options, etc.). Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the DPO, including any possible conflicts of interest.
- C. If the applicant is a subsidiary of a parent or holding company, provide an organizational chart showing the relationship of all related companies.

Section IV-2 Biographical Affidavits for Officers, Directors and Shareholders [s.636.204(2)(d),F.S.]

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, any person having direct or indirect control of the organization, including but not limited to contracted management company personnel and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. All "Yes" answers must be explained.

Each biographical affidavit must contain an original signature and original notary seal.

The requirement for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to Sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on the Biographical Affidavit, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also please mark CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 Investigative Background Reports [636.204(2)(d) F.S.]

A Background Investigative Report must be provided for each person listed in Section IV-1 above except for those companies in the organizational structure between the immediate parent and the ultimate parent. Background reports must be submitted by the selected background investigator vendor prior to or contemporaneously with the application filing. Please refer to form OIR-C1-905 REV 02/15 for instructions.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in Section IV-1. The cards will be furnished by the Office upon request. **No cards other than those furnished by the Office will be accepted.** The cards must be completed at a law enforcement agency and returned to this Office for processing. Please refer to Form OIR-C1-938 for instructions.

Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards and fees as noted above. Please refer to Form OIR-C1-938.

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**CHECK LIST
SECTION I - APPLICATION FEES AND FORM**

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Insurer application fees paid.....	☐
(a) Copy of invoice included (Official Form).....	☐
(b) Copy of check.....	☐
(c) Originals mailed to Revenue Processing Section.....	☐
2. Fingerprint fee paid electronically.....	☐
a. Copy of on-line payment confirmation.....	☐
3. Application for License (Official Form).....	☐
(a) All blanks completed.....	☐
(b) If applicable, sealed by corporation.....	☐
(c) Signed by President or other authorized officer (original signature).....	☐

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION II – LEGAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Articles of Incorporation or other organizing documents and all amendments attached with an original certification by the State of Domicile	☐
2. Certificate of Status from Florida Secretary of State (original document)	☐
(a) Good standing indicated.....	☐
(b) Sealed by state.....	☐
(c) Signed by proper public official.....	☐
(d) Original.....	☐
3. Corporate By-Laws, Rules and Regulations, and/or Constitution	☐
(a) Signed and dated by applicant's secretary.....	☐
4. Certificate of Compliance from State of domicile.....	☐
(a) Original Certification from State of domicile.....	☐
(b) Form indicates the kinds of contracts the company is authorized to transact.....	☐
(c) Not applicable.....	☐
5. Service of Process Form.....	☐

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Marketing and growth	☐
(a) Description of marketing methods.....	☐
2. Advertising	☐
(a) Include a description of advertising procedures.....	☐
3. Provide website address	☐
4. Financial	☐
A. Current audited financial statements & fiscal year end date...	☐
B. Compliance with minimum surplus requirement.	☐
C. Original document evidencing compliance with surety bond requirement or security deposit requirement as explained in S.III-4C 1&2	☐
5. Contractual Documents	☐
(a) Provider contract form	☐
(b) Other forms of contracts per s.636.204(2)(h), F.S.	☐
(c) Other forms of contracts per s.636.204(2)(c) and (g), F.S.	☐
6. Statement describing facilities, personnel, and medical services...	☐
7. Description of subscriber complaint procedures.....	☐

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION IV – MANAGEMENT

Note: This portion of the checklist is detailed in order to assist the applicant in ensuring all items are completed, and checklist item numbers will not correlate with item numbers in the Instructions.

<u>Item #</u>		<u>Completion Check List</u>
1.	Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-1298)	☐
2.	Listing of all <u>immediate</u> parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
3.	Listing of all <u>intermediary</u> parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298). Note, do not complete Form OIR-C1-1423, (Biographical Affidavits) or order investigative reports or fingerprint cards.....	☐
4.	Listing of all <u>ultimate</u> parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
5.	Organizational Chart including all entities within the ultimate parent company structure.....	☐
6.	Biographical Affidavits for company officers, directors, and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423)	☐
As to each biographical:		
(a)	All blanks completed.....	☐
(b)	Contains original signature	☐
(c)	Notarized (original)	☐
(d)	SSN on a separate page.....	☐

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**SECTION IV – MANAGEMENT
Required Filing and Check list**

7. Biographical Affidavits for immediate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent Company's stock (Form OIR-C1-1423) ☐
- As to each biographical:**
- (a) All blanks completed..... ☐
- (b) Contains original signature..... ☐
- (c) Notarized (original)..... ☐
- (d) SSN on a separate page..... ☐
8. Biographical Affidavits for ultimate parent(s) officers, directors, and Shareholders (including entities) owning 10% or more of parent company's Stock (Form OIR-C1-1423)
- As to each biographical:**
- (a) All blanks completed..... ☐
- (b) Contains original signature..... ☐
- (c) Notarized (original)..... ☐
- (d) SSN on a separate page..... ☐
9. Background investigative reports for company officers, directors, and shareholders (including entities) owning 10% or more of applicant..... ☐
10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock..... ☐
11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock..... ☐

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

Note: If fingerprints are digitally scanned, Items 12, 13 and 14 are not applicable.

12. Fingerprint cards completed for each company officer, director, and shareholder (including entities) owning 10% or more of applicant ☐

As to each fingerprint card:

- (a) Contains original signature..... ☐
- (b) Florida cards only..... ☐
- (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ☐

13. Fingerprint cards completed for each immediate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

As to each fingerprint card:

- (a) Contains original signature..... ☐
- (b) Florida cards only..... ☐
- (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ☐

14. Fingerprint cards completed for each ultimate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

- (a) Contains original signature..... ☐
- (b) Florida cards only..... ☐
- (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page)..... ☐

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by (Entity Name)_____ that he/she has read said application, that he/she knows the contents thereof and verifies that the items indicated in the application checklist have been submitted with the application, that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the applicant on behalf which the person acted, executed the instrument.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes.

Dated _____
(Give full and exact name of applicant)

Signature of President, Secretary, or Treasurer

Printed Name

Printed Title

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

Pursuant to Chapter 636, Part II Florida Statutes, application is hereby submitted to form and operate a Discount Plan Organization.

In order to qualify as a Discount Plan Organization (DPO), an entity must:

- A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, part I of Chapter 607, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S. [s., 636.204(1), F.S.];
- B. Be an entity which, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

Proposed name of Discount Plan Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

CONTACT PERSON: _____

E-MAIL: _____ FAX: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ E-MAIL: _____ FAX: _____

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

APPLICATION CERTIFICATION

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ (“Applicant”) to apply to operate as a _____ in this state; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

(Corporate Seal)

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20__, by _____
(name of person)

as _____ for _____
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**INVOICE
PAYMENT OF APPLICATION FEE**

NAME OF COMPANY: _____

FEIN #: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

_____ (CITY) (STATE) (ZIP CODE)

E-MAIL ADDRESS: _____ FAX: _____

In reference to the recent submission by the above-referenced discount ~~medical~~ plan organization regarding its application to do business in Florida, it is necessary that you return this form with the proper payment as listed below.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail check and invoice only to the Florida Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

If you have any questions, please contact Applications Coordination at (850) 413-2575.

	<u>B/T</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
Filing Fee	C	1249F	F	\$ 50.00



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

OIR-C1-2221

Rev.: 6/20

Rule: 690-203.210

690-193.003 Applications and Management Change.

(1) Application for Certificate of Authority.

(a) An application for a person applying for a certificate of authority for a continuing care provider consists of the following:

1. Form OIR-C1-473, "Application for Certificate of Authority for a Continuing Care Provider," effective 9/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11565>;

2. Form OIR-C1-144, "Service of Process Consent & Agreement," effective 6/04, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11566>;

3. Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," effective 6/20 4/19, hereby incorporated by reference and available at www.flrules.org/XXXXX <https://www.flrules.org/Gateway/reference.asp?No=Ref-11567>;

4. Form OIR-C1-938, "Fingerprint Payment and Submission Procedures," effective 6/20 4/19, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref-11568>;

5. Form OIR-C1-1423, "Uniform Certificate of Authority Application (UCAA) Biographical Affidavit," effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX; and Form OIR-C1-2221, "Management Information Form," effective 11/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11569>; and

6. Form OIR-C1-2221, "Management Information Form," effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX; Form OIR-C1-1423, "Biographical Affidavit," effective 4/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11570>.

(b) A person applying for a certificate of authority as a continuing care provider shall submit forms in paragraph (1)(a) as directed by the Office electronically at <https://www.flair.com/iportal>.

(2) Application for Provisional Certificate of Authority.

(a) An application for a person applying for a provisional certificate of authority for a continuing care provider consists of the following:

1. Form OIR-C1-471, "Application for Provisional Certificate of Authority for a Continuing Care Provider," effective 9/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11571>;

2. Form OIR-C1-144, incorporated by reference in paragraph (1)(a);

3. Form OIR-C1-905, incorporated by reference in paragraph (1)(a);

4. Form OIR-C1-938, incorporated by reference in paragraph (1)(a);

5. Form ~~OIR-C1-1423~~ ~~OIR-C1-2221~~, incorporated by reference in paragraph (1)(a); and

6. Form ~~OIR-C1-2221~~ ~~OIR-C1-1423~~, incorporated by reference in paragraph (1)(a).

(b) A person applying for a provisional certificate of authority as a continuing care provider shall submit forms in paragraph (2)(a) as directed by the Office electronically at <https://www.flair.com/iportal>.

(3) Consolidated Application for Provisional Certificate of Authority and Certificate of Authority.

(a) A consolidated application for a provisional certificate of authority and certificate of authority for a continuing care provider consists of the following:

1. Form OIR-C1-2220, "Consolidated Application for Provisional Certificate of Authority and Certificate of Authority for a Continuing Care Provider," effective 9/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11572>;

2. Form OIR-C1-144, incorporated by reference in paragraph (1)(a);

3. Form OIR-C1-905, incorporated by reference in paragraph (1)(a);

4. Form OIR-C1-938, incorporated by reference in paragraph (1)(a);

5. Form ~~OIR-C1-1423~~ ~~OIR-C1-2221~~, incorporated by reference in paragraph (1)(a); and

6. Form ~~OIR-C1-2221~~ ~~OIR-C1-1423~~, incorporated by reference in paragraph (1)(a).

(b) A person filing a consolidated application for provisional certificate of authority and certificate of authority for a continuing care provider shall submit forms in paragraph (3)(a) as directed by the Office electronically at <https://www.flair.com/iportal>.

(4) Application for the Simultaneous Acquisition of a Continuing Care Facility and Issuance of a Certificate of Authority to a Provider.

(a) An application for the simultaneous acquisition of a continuing care facility and issuance of a certificate of authority consists of the following:

1. Form OIR-C1-2219, "Application for the Simultaneous Acquisition of a Continuing Care Facility and Issuance of a Certificate of Authority to a Provider," effective 9/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11573>;

2. Form OIR-C1-144, incorporated by reference in paragraph (1)(a);

3. Form OIR-C1-905, incorporated by reference in paragraph (1)(a);

4. Form OIR-C1-938, incorporated by reference in paragraph (1)(a);

5. Form ~~OIR-C1-1423~~ ~~OIR-C1-2221~~, incorporated by reference in paragraph (1)(a); and

6. Form ~~OIR-C1-2221~~ ~~OIR-C1-1423~~, incorporated by reference in paragraph (1)(a).

(b) A person applying for simultaneous acquisition of a continuing care facility and issuance of a certificate of authority shall submit forms in paragraph (4)(a) as directed by the Office electronically at <https://www.floir.com/iportal>.

(c) Disclaimer of Control

1. A person may attempt to rebut a presumption of control pursuant to Section 651.0245, F.S., by electronically filing at <https://www.floir.com/iportal> one of the following forms with the Office:

a. Form OIR-C1-1467, "Disclaimer of Control Affidavit – Individual," effective ~~7/21~~ ~~08/18~~, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref-11574>;

b. Form OIR-C1-1468, "Disclaimer of Control Affidavit – Entity," effective ~~7/21~~ ~~08/18~~, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref-11575>;

c. Form OIR-C1-2211, "Disclaimer of Control Affidavit – Investment Companies," effective ~~7/21~~ ~~08/18~~, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref-11576>.

2. A person may attempt to rebut a presumption of control pursuant to section 651.0245, F.S., by filing a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended, to the Office electronically at <https://www.floir.com/iportal>.

3. Pursuant to Section 651.0245(6), F.S., the Office is authorized to disallow a disclaimer of control filed pursuant to subparagraphs (4)(c)1. and (4)(c)2.

(5) Application for Expansion.

(a) An application for a person applying for expansion of a certificated continuing care facility consists of the following:

1. Form OIR-C1-2218, "Application for Expansion of a Certificated Continuing Care Facility," effective 9/19, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-11577>;

2. Form OIR-C1-905, incorporated by reference in paragraph (1)(a);

3. Form OIR-C1-938, incorporated by reference in paragraph (1)(a);

4. Form ~~OIR-C1-1423~~ ~~OIR-C1-2221~~, incorporated by reference in paragraph (1)(a); and

5. Form ~~OIR-C1-2221~~ ~~OIR-C1-1423~~, incorporated by reference in paragraph (1)(a).

(b) A person applying for expansion of a certificated continuing care facility shall submit forms in paragraph (5)(a) as directed by the Office electronically at <https://www.floir.com/iportal>.

(6) Manager or Management Company.

(a) To comply with the filing requirements of Section 651.043(2), F.S., for each new management company or manager not employed by a management company within 10 business days of a change in management, the provider shall submit the following:

1. Form OIR-C1-905, ~~incorporated by reference in paragraph (1)(a) "Instructions for Furnishing Background Investigative Reports," effective 2/15, hereby incorporated by reference and available at~~ <http://www.flrules.org/Gateway/reference.asp?No=Ref-11567>;

2. Form OIR-C1-938, ~~incorporated by reference in paragraph (1)(a) "Fingerprint Payment and Submission Procedures," effective 10/18, hereby incorporated by reference and available at~~ <http://www.flrules.org/Gateway/reference.asp?No=Ref-11568>; and

3. Form OIR-C1-1423, ~~incorporated by reference in paragraph (1)(a) "Biographical Affidavit," effective 4/19, hereby incorporated by reference and available at~~ <http://www.flrules.org/Gateway/reference.asp?No=Ref-11570>.

4. A copy of the written management contract, if applicable.

(b) The documents in paragraph (6)(a) shall be submitted to the Office electronically at <https://www.floir.com/iportal>.

Rulemaking Authority 651.015(3), 651.021(2), 651.022(2), 651.0245(3), (5), (6), 651.0246(1), 651.043 FS. Law Implemented 651.0215, 651.022, 651.023, 651.024, 651.0245, 651.0246 FS. History—New 7-16-92, Formerly 4-193.003, Amended 3-12-20,_____.

690-193.005 Monthly, Quarterly, and Annual Reports.

(1) Monthly Statements.

If required by the Office pursuant to Section 651.0261(3), F.S., a provider shall file Form OIR-A3-973 within 25 days after the end of each month. Form OIR-A3-973, “Monthly Financial Report,” effective 7/20 9/19, is hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref 11558>. The filing shall be submitted electronically via the Office’s system at <https://www.floir.com/iportal>.

(2) Quarterly Statements.

(a) As required by Section 651.0261(2), F.S., a provider shall file Form OIR-A3-974 within 45 days after the end of the fiscal quarter. Form OIR-A3-974, “Quarterly Financial Report,” effective 7/20 9/19, is hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref 11559>. The filing shall be submitted electronically via the Office’s system at <https://www.floir.com/iportal>.

(b) In addition to Form OIR-A3-974, a provider shall submit Form OIR-A3-1245 for any facility for which a certificate of occupancy has not yet been issued. Form OIR-A3-1245, “Sales and Financial Report for a Non-Operational Facility,” effective 7/20 9/19, is hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref 11560>.

(3) Annual Report.

An Annual Report shall be filed with the Office, on or before May 1 of each year if the provider’s fiscal year end is December 31 or within 120 days of the last day of the fiscal year of the provider if the provider has declared a fiscal year other than the calendar year, on Form OIR-A3-470, “Annual Financial Report,” effective 7/20 9/19, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref 11561>. The filings shall be submitted electronically via the Office’s system at <https://www.floir.com/iportal>.

Rulemaking Authority 651.015(3), 651.026(2), (9), 651.0261(1), (2), (4) FS. Law Implemented 651.026, 651.0261 FS. History—New 7-16-92, Formerly 4-193.005, Amended 3-12-20,_____.

690-193.050 Minimum Liquid Reserve Requirement.

(1) A Minimum Liquid Reserve (MLR) Calculation shall be filed with the Office, on or before May 1 of each year if the provider’s fiscal year end is December 31 or within 120 days of the last day of the fiscal year of the provider if the provider has declared a fiscal year other than the calendar year, on Form OIR-A3-477, “Minimum Liquid Reserve (MLR) Calculation,” effective 7/20 10/19, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref 11562>. The filings shall be submitted electronically at <https://www.floir.com/iportal>.

(2) The Office may require a recalculation of the minimum liquid reserve requirement and resubmission of Form OIR-A3-477 in the event of additional long-term financing or other occurrences resulting in a change to the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loans or other long-term financing or a change to all leasehold payments and all costs related to such payments financing of the facility. Any increase in required minimum liquid reserves must be funded not later than 61 days after the minimum liquid reserve calculation is filed.

(3) For purposes of the MLR requirement, long-term financing includes, ~~but is not limited to,~~ lease payments, mortgage payments, the long-term portion of any construction loan, and any long-term debt between affiliates or controlling parties of the provider that relate to the real property or fixtures of a facility.

(4) Where a provider has elected to fund the MLR upon release of entrance fees as provided by Section 651.023(6)(d), F.S., the funds shall be deposited directly from the entrance fee account into MLR accounts.

(5) A provider shall have and maintain reserves for property taxes as provided in Section 651.035, F.S., even if there is no long-term debt or financing on the facility.

(6) To request Office approval of a withdrawal of MLR funds, a provider must file Form OIR-A3-1284, “Request for Withdrawal from Minimum Liquid Reserves,” effective 7/20 10/19, hereby incorporated by reference and available at www.flrules.org/XXXXX <http://www.flrules.org/Gateway/reference.asp?No=Ref 11563>. The filing shall be submitted electronically at <https://www.floir.com/iportal>.

(7) If a provider, or its escrow agent or trustee, intends to use funds from a debt service reserve that is included in computing a provider's minimum liquid reserve pursuant to Section 651.035(1)(b), F.S., rather than filing Form OIR-A3-1284 as required in subsection (6) above, the following process applies:

(a) The provider, or its escrow agent or trustee if so authorized in the agreement under which such debt service reserve is held, shall submit the documents listed below.

1. An affidavit, sworn to by an officer or director of the provider, stating that the provider anticipates being unable to make its scheduled debt service payment and a withdrawal from the debt service reserve included in the minimum liquid reserves pursuant to Section 651.035(1)(b), F.S., is required to avoid a payment default. The affidavit shall include all of the following information:

- a. The amount of the payment;
- b. The payment due date;
- c. The maximum amount of the withdrawal needed to make the payment;
- d. The date the anticipated date of the withdrawal;
- e. The account(s) from which the withdrawal will be made, which should match the account information and escrow statements previously provided to the Office; and
- f. If there is a discrepancy in this account information, a written explanation of the discrepancy and any relevant documentation at the time of filing.

2. A document providing the following information with respect to the effect of the withdrawal on the provider's minimum liquid reserves and compliance with Section 651.035, F.S.

a. A statement of whether the lender or trustee will require the provider to deposit additional funds in the debt service reserve to repay the amount withdrawn.

b. If the provider will be required to deposit additional funds in the debt service reserve to repay the amount withdrawn, the anticipated or proposed schedule for funding.

c. If the withdrawal will result in the provider being out of compliance with Section 651.035, F.S., the provider shall submit a preliminary plan or anticipated timeline for coming into compliance. If the provider intends to work with a consultant to establish a plan, as proscribed in its financing documents, the provider should provide a brief explanation of that process and the anticipated date that such a plan will be completed.

(b) The request must be made at least 30 days before the anticipated date of the withdrawal.

(c) The Office will approve requests that contain all of the components specified in paragraph (7)(a) within 30 days of filing.

(d) The Office's approval of a withdrawal from a debt service reserve included in the minimum liquid reserves pursuant to Section 651.035(1)(b), F.S., does not constitute approval of the plan submitted pursuant to subparagraph (7)(a)2.c. above.

(e) The filing shall be submitted electronically at <https://www.flair.com/iportal>.

Rulemaking Authority 651.015(3), 651.026(2)(d), 651.035(9) FS. Law Implemented 651.026, 651.035 FS. History—New 7-16-92, Formerly 4-193.050, Amended 3-12-20,_____.

690-193.053 Waiver of Minimum Liquid Reserves.

(1) If principal and interest payments are paid to a trust that is beneficially held by residents as described in Section 651.023(7), F.S., the Office may waive all or any portion of the escrow requirements for mortgage principal and interest if the Office finds that such waiver is not inconsistent with the security protections intended by Chapter 651, FS.

(2) To obtain a waiver for all or any part of the escrow requirement for mortgage principal and interest contained in Section 651.035(1), F.S., the provider must meet the requirements of Section 651.023(7), F.S., and file Form OIR-A3-1068, "Request for Waiver of Minimum Liquid Reserve Requirement," effective ~~7/20/19~~ 7/20/19, hereby incorporated by reference and available at www.flrules.org/XXXXX. <http://www.flrules.org/Gateway/reference.asp?No=Ref-11564>, The filings shall be submitted electronically at <https://www.flair.com/iportal>;

(3) For a new facility commencing operations, Form OIR-A3-1068 must be submitted no later than 30 days before the provider requests the release of moneys held in escrow pursuant to Section 651.023(6), Florida Statutes. For a provider whose after escrowed funds have been released, Form OIR-A3-1068 shall be filed with the Office, on or before May 1 of each year if the provider's fiscal year end is December 31 or within 120 days of the last day of the fiscal year of the provider if the provider has declared a fiscal year other than the calendar year.

(4) Any previous waiver granted by the Office terminates as of the date the provider is required to file its next MLR calculation. If the subsequent request for waiver is denied, the provider shall have 61 days from the date MLR

calculation and Request for Waiver of Minimum Liquid Reserve were due to be filed to fully fund the required reserve accounts.

Rulemaking Authority 651.015(3) FS. Law Implemented 651.023, 651.035 FS. History—New 7-16-92, Formerly 4-193.053, Amended 3-12-20,_____.



Florida Office of Insurance Regulation

ANNUAL FINANCIAL REPORT

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

ANNUAL FINANCIAL REPORT OF

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

FOR PERIOD ENDED

Facility Name:
Period Ending:

GENERAL INFORMATION AND INSTRUCTIONS

The Florida Office of Insurance Regulation (“Office”) issues a Certificate of Authority to the Provider, which is the legal entity that issues contracts for continuing care for a Facility, including residency agreements, reservation agreements, and waitlist agreements. Separate Certificates of Authority are issued for each Facility, which can result in a single Provider holding multiple Certificates of Authority and, therefore, submitting multiple reports for the same period. In addition to operating multiple Facilities, it is not unusual for Providers to engage in business other than providing continuing care in Florida. As a result, the Office requires financial information at the Provider and Facility level to evaluate the financial condition.

Further, many continuing care Providers are part of holding company structures through which they are affiliated with other Florida Providers through common ownership or control. These instructions are intended to clarify reporting requirements so that the Office has a clear understanding of the participants in the Florida market, regardless of organizational structure.

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
2. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
3. Submit this form electronically via the Office’s system at <https://www.flair.com/iportal>.
4. All questions and portions of this form must be completed in order for the filing to be considered complete—do not leave any items blank. For the financial statements, please ensure to enter 0 for numerical values and N/A for text responses, as appropriate, rather than leaving the field blank.
5. If additional explanations, supporting statements, documentation, or schedules are necessary, please upload them to the filing by attaching them as a Miscellaneous Document. Please add a label to the Miscellaneous Document that describes the attachment for ease of reference. Any attachments should be in a readable electronic format (i.e. Word, Excel, PDF, etc.).
6. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.
7. Financial Statements. Provide a Balance Sheet, Statement of Operations, and Statement of Cash Flows (collectively “Financial Statements”) for both the Facility and the Provider. If operating the Facility is the Provider’s only business, we would expect the Financial Statements for the Provider and Facility to be identical. If the Provider has more than one Facility or is engaged in other business in addition to operating the Facility, we would expect the Facility’s Financial Statements to reflect the financial position and operations of the Facility as a sub-unit of the Provider and the Provider’s Financial Statements to reflect the financial position of the Provider and all of its operations.
8. Minimum Liquid Reserves. Section 651.035, Florida Statutes, establishes minimum liquid reserve requirements that must be maintained by a Provider for each Facility. Minimum liquid reserve (“MLR”) funds must be maintained in escrow or on deposit with the Department of Financial Services, Bureau of Collateral Management. MLR funds are recorded in Lines 6a and 11a of the Balance Sheet.

In addition, Providers shall submit a schedule detailing MLR funding and accounts. Providers with financing on the Facility should complete SCHEDULE A and not SCHEDULE B. Providers without financing on the Facility should complete SCHEDULE B and not SCHEDULE A.

9. Escrow Statements. To document compliance with the Minimum Liquid Reserve Requirement, please upload escrow statements as a component of this filing. For the purpose of SCHEDULE A and SCHEDULE B, If a Provider uses a single MLR account for one or more of the Facility’s MLR reserves, the Provider

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should evenly apportion the funds between the appropriate reserve types for the purpose of completing the MLR schedule.

10. If a Provider owns more than one Facility, or if the Provider is affiliated through common ownership or control with additional Providers owning Facilities in Florida, please include a Provider Group Code on the cover page for the monthly, quarterly, and annual filings.
11. Obligated Groups. A Provider that is a member of an Obligated Group should complete SCHEDULE D and should not complete SCHEDULE C. A Provider that is not a member of an Obligated Group should complete SCHEDULE C and should not complete SCHEDULE D.
12. Before submitting this filing, please compare this report, the Minimum Liquid Reserve Calculation, and the audited financial statements to ensure that all of the required filings are accurate and that amounts reported are consistent between documents.

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ATTESTATION

This filing will not be considered complete unless it has attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies the page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

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PROVIDER INFORMATION

Provider Name: _____

Provider Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Provider Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____

Contact Title: _____

Phone: _____ Ext: _____

Email Address: _____

Federal Employer Identification Number (FEIN): _____

1. Please select the type of organization that describes the Provider.

- ☐ For-profit corporation
- ☐ Not-for-profit corporation
- ☐ General Partnership
- ☐ Limited Partnership
- ☐ Trust
- ☐ Joint Venture
- ☐ Limited Liability Company
- ☐ Other: _____

2. Is the Provider affiliated with or sponsored by a not-for-profit organization?

- ☐ Yes
- ☐ No

a. If yes, please provide the name of the affiliated or sponsoring organization. _____

3. Is the Provider affiliated with a religious organization?

- ☐ Yes
- ☐ No

a. If yes, please provide the name of the religious organization. _____

4. Please provide the Florida Company Code of every CCRC in Florida for which the Provider is licensed pursuant to Chapter 651, Florida Statutes. Please separate Florida Company Codes with a comma.

5. Provide the following information regarding every CCRC owned or managed by the Provider.

Facility Name	Location (select state)	Owned (check box if yes)	Managed (check box if yes)

Facility Name:

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6. Does the Provider use a management company to manage this Facility?

- ☐ Yes
- ☐ No

If yes, provide the following information:

- a. Name of the management company: _____
- b. Date of execution of the current management agreement: _____
- c. Expiration date of the current management agreement: _____
- d. Provide the information below regarding every CCRC owned or managed by the management company.

Facility Name	Location (select state)	Owned (check box if yes)	Managed (check box if yes)

7. Does the Provider pay commission to any officer, director, or salaried employee?

- ☐ Yes
- ☐ No
- a. If yes, please provide the following information.

Name	Position

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8. Were debt service payments due for the Provider during the reporting period?

- ☐ Yes
- ☐ No

a. If yes, for each lender, please provide the information below regarding the debt service payments due during the reporting period.

Lender(s)	A Principal	B Interest	C Taxes	D Insurance	E Debt Service per Lender (Sum of A through D)	Payments Timely Made? (Select Yes or No)
1.						
2.						
3.						
4.						
5.						
6. Total Debt Service						

9. Does the Provider have any balloon payments due on debt related to this Facility within 3 years of the period ended date of this filing?

- ☐ Yes
- ☐ No

If yes, please provide the following:

- a. The amount of the balloon payment: _____
- b. Name of the lender: _____
- c. The due date for the balloon payment: _____

10. Upload an audited financial report for the Provider that meets the requirements of section 651.026(2)(b) and (c)(6), Florida Statutes.

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FACILITY INFORMATION

Facility Name: _____

Facility Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ County: _____

Provider Mailing Address: _____

City: _____ State: _____ Zip: _____

Executive Director: _____

Phone: _____ Ext: _____

Email Address: _____

1. What is the estimated market value of the Facility? _____
2. What is the as of date for the estimated value provided above? _____
3. Provide the following information regarding all insurance coverage and upload proof of coverage as an attachment to this filing.

Insurer	Coverage Type	Coverage Limit	Deductible /Retention

4. Facility owned by: _____
5. Name of entity which the Facility or any part of Facility (ex. ground lease, building lease, etc.) is leased to:

6. Name of entity which the Facility or any part of Facility (ex. ground lease, building lease, etc.) is leased from:

7. If the Facility's records are not located on site, please provide the address where its records are located:

Please provide the following information regarding any units that have been added to the Facility during the reporting period (a certificate of occupancy has been issued) or are currently under construction.

For Assisted Living and Memory Care Units, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date in Line 9. Report the number of units that the Provider considers to be Memory Care Units as of the reporting date in Line 10. If the Provider does not make a distinction between Assisted Living and Memory Care or if a decision regarding whether the units will be used for Memory Care has not been made, please report all units as Assisted Living in Line 9 and enter 0s for Line 10.

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	A Added	B Under Construction
8. Independent Living Units		
9. Assisted Living Units		
10. Memory Care Units		
11. Total Assisted Living (Line 9 + Line 10)		
12. Community Beds		
13. Sheltered Beds		
14. Total Skilled Nursing Beds (Line 12 +Line 13)		
15. Total Units (Sum of Lines 8, 11, and 14)		

16. Where any additional independent living/community common spaces constructed this year?

- ☐ Yes
- ☐ No

17. Was a new assisted living or memory care facility constructed during this year?

- ☐ Yes
- ☐ No

18. Was a new skilled nursing facility constructed during this year?

- ☐ Yes
- ☐ No

19. Did the Provider undertake a substantial renovation project for existing units?

- ☐ Yes
- ☐ No

20. Has the Provider remodeled or reconfigured the Facility to combine or otherwise permanently reduce the number of units?

- a. Yes
- b. No

21. Did the Provider incur any additional debt to related to construction costs?

- ☐ Yes
- ☐ No
- i. If yes, how much new debt was incurred? _____

If the Provider's plans for future construction projects at the Facility are publicly available, please provide the following information regarding any units that the Provider plans to add to the Facility in the next 3 years (3 years from the period ended date of this filing).

For Assisted Living and Memory Care Units, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date in Line 23. Report the number of units that the Provider considers to be Memory Care Units as of the reporting date in Line 24. If the Provider does not make a distinction between Assisted Living and Memory Care or if a decision regarding whether the units will be used for Memory Care has not been made, please report all units as Assisted Living in line 23 and enter zeroes for line 24.

	A Number of Units to Be Added	
22. Independent Living Units		
23. Assisted Living Units		
24. Memory Care Units		
25. Total Assisted Living (Line 22 + Line 23)		
26. Community Beds		
27. Sheltered Beds		
28. Total Skilled Nursing Beds (Line 26 + Line 27)		
29. Total Units (Sum of Lines 22, 25, and 28)		
30. Does the plan to any additional independent living/community common spaces to the Facility in the next three years?		Provider construct

- ☐ Yes

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☐ No

31. Does the Provider plan to construct a new assisted living or memory care facility within the next 3 years?

☐ Yes
☐ No

32. Does the Provider plan to construct a new skilled nursing facility within the next 3 years?

☐ Yes
☐ No

33. Does the Provider plan to begin a substantial renovation project for existing units within the next 3 years?

☐ Yes
☐ No

34. Does the Provider plan to remodel or reconfigure the Facility to combine or otherwise permanently reduce the number of units within the next 3 years?

☐ Yes
☐ No

35. Does the Provider plan to incur any additional debt to related to construction costs within the next 3 years?

☐ Yes
☐ No.

a. If yes, how much new debt is estimated to be incurred? _____

36. Were debt service payments due specifically related to this Facility during the reporting period?

☐ Yes
☐ No

If yes, for each lender, please provide the following information regarding the Provider's debt service payments that were due during the reporting period.

Lender(s)	A Principal	B Interest	C Taxes	D Insurance	E Debt Service per Lender (Sum of A through D)	Payments Timely Made? (Select Yes or No)
37.						
38.						
39.						
40.						
41.						
42. Total Debt Service						

43. Does the Provider have any balloon payments due on debt related to this Facility within 3 years of the period ended date of this filing?

☐ Yes
☐ No

If yes, please provide the following:

a. The amount of the balloon payment: _____

b. The name of the lender: _____

c. The due date for the balloon payment: _____

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RESIDENTS' COUNCIL AND MEETING INFORMATION

1. Please provide the following information for the President, Chair, or person performing a similar function, of the Residents' Council or similar body:

- a. Name: _____
- b. Phone: _____
- c. Email Address: _____

2. Please provide the following information regarding the quarterly meetings required by section 651.085, Florida Statutes:

Date of Quarterly Meeting	Date Notice of Quarterly Meeting Was Provided	Name & Title of Provider Representative(s) in Attendance	Monthly Fee Increases Discussed? (select yes or no)	Summary of Reasons for Fee Increase Provided in Writing? (select yes or no)

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FEES AND CHARGES

1. Please upload the fee schedules in affect as-of the period ended date of this filing in as Excel file or in readable PDF format. As applicable, please provide a fee schedule for each of the following:
- Entrance fees – continuing care contracts;
 - Monthly maintenance fees – continuing care contracts;
 - Fees charged for assisted living care;
 - Fees charged for memory care; and
 - Fees charged for skilled nursing care.

Please provide the following range of fees for continuing care contracts:

	A Lowest Fee	B Highest Fee
2. Entrance fee		
3. 2 nd person entrance fee		
4. Monthly maintenance fee		
5. 2 nd person maintenance fee		

6. How does the Provider apply the proceeds of entrance fees received? Please check all that apply:
- ☐ To pay down long-term debt
 - ☐ To pay operating expenses
 - ☐ To fund construction or renovation
 - ☐ To pay resident refunds
 - ☐ Other: _____
7. If the entrance fee is not the same in all cases, how is the amount of the entrance fee determined? Please check all that apply:
- ☐ Entrance fee varies by unit type
 - ☐ Entrance fee changes based on market conditions or marketing promotions
 - ☐ Entrance fee varies based on healthcare services provided
 - ☐ Entrance fee varies based on services provided other than healthcare benefits (number of meals, housekeeping, etc.)
 - ☐ Entrance fee varies based on whether a portion of the entrance fee is refundable regardless of the length of the resident's occupancy or if the entrance fee will amortize to 0% refundable
 - ☐ Entrance fee varies based on timing of the refund payment
 - ☐ Entrance fees vary by the age or health of the prospective resident
 - ☐ Other: _____

Regardless of whether the change involves the basic rate or only those services available at additional cost the resident, please provide the following information:

8. Has the Provider changed or increased fees during the reporting period?
- ☐ Yes, fees increased, If so, by how much on average? a. _____ %
 - ☐ No, fees stayed the same
 - ☐ No, fees decreased. If so, by how much on average? b. _____ %
9. Has the Provider changed the scope of care or services during the reporting period?
- ☐ Yes, the provider provides a broader scope of care or services than last year
 - ☐ Yes, the provider provides a narrower scope of care or services than last year
 - ☐ No, the scope of care or services is the same as last year
10. Has the Provider changed the rates for care or services during the reporting period?
- ☐ Yes, the rates for care or services increased, If so, by how much on average? a. _____ %
 - ☐ Yes, the rates for care or services decreased. If so, by how much on average? b. _____ %
 - ☐ No, the rates for care or services stayed the same

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RESIDENT COUNT

For each category below, specify the total number of individuals at this Facility as of the end of the reporting period. Continuing care at-home residents should not be included in lines 1 through 4.

Level of Care	A Pursuant to a Continuing Care Contract	B Without a Continuing Care Contract
1. Independent Living		
2. Assisted Living and Memory Care		
3. Skilled Nursing		
4. Total (Sum of Lines 1, 2 and 3)		

5. Please specify how many individuals have contracted with the Provider pursuant to a continuing care at-home contract for this Facility: _____
6. Provide the average age of the resident population: _____

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CONTINUING CARE CONTRACTS

Using the definitions below, please complete the following table regarding the number of continuing care contracts in force at this Facility. Please provide the number of the Provider's in force continuing care contracts that fit in each category. Choose the best fit using the definitions below.

Type A or "Extensive" or Life Care" Contracts: continuing care contracts that provide lifetime access to independent living and assisted living or skilled nursing care with little or no increase in the monthly fee as the result of moving to a higher level of care.

Type B or "Modified" Contracts: continuing care contracts that offer a less extensive health care benefit than Type A contracts, but more benefits than a fee-for-service contract. Type B contracts may provide for a slightly discounted rate for assisted living or skilled nursing care, a limited period of assisted living or skilled nursing care, or a set amount of funds to be credited toward charges for assisted living or skilled nursing care. If residents exhaust their healthcare credit or remain at a higher level of care for a greater period of time than the number of days established in their continuing care contract, they pay a stated daily rate for care.

Type C or "Fee-for-Service" Contracts: continuing care contracts that grant residents exclusive or priority access to assisted living or skilled nursing care, but do not provide any discounts for assisted living or skilled nursing care. Residents at a higher level of care are charged the stated daily rate.

Traditional Refund Clause: a clause in a Type A, Type B, or Type C continuing care contract whereby the resident's entrance fee amortizes down to a 0% refund of the entrance fee based on months of occupancy by the resident.

Refundable Clause: a clause in a Type A, Type B, or Type C continuing care contract that provides the resident with a right to a refund of a specified percentage their entrance fee regardless of the number of months of occupancy, subject to terms and conditions.

	A Traditional Refund Clause	B Refundable Clause
1. Type A		
2. Type B		
3. Type C		

Please provide the following information regarding the Provider's refund liability for this Facility.

	A Current Reporting Period	B Previous Annual Reporting Period
4. Contractual liability for refundable entrance Fees		
5. Contractual refund obligations assuming all contracts were terminated		

6. Please provide the OIR Form Filing Numbers for the continuing care contracts that the Provider has not discontinued writing at this Facility. Please separate each form filing number with a comma.

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7. Is the estimated present value of the net cost of future services and use of facilities less than the deferred revenue from entrance fees?
- ☐ Yes
 - ☐ No
- a. If the estimated present value of the net cost of future services and use of facilities exceeds the deferred revenue from entrance fees, has the Provider recorded a liability representing the obligation to provide future services and use of facilities to residents?
- ☐ Yes
 - ☐ No
 - ☐ Not Applicable
- b. If a liability was recorded, what is the amount of the liability representing the obligation to provide future services and use of facilities? _____

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ASSISTED LIVING/MEMORY CARE AND SKILLED NURSING INFORMATION

Skilled Nursing

1. Do the Provider's continuing care contracts provide for skilled nursing services?
 - ☐ Yes
 - ☐ NoIf yes, please provide the following:
 1. The name of the skilled nursing provider _____
 2. Is the skilled nursing provider an affiliate of the Provider?
 - ☐ Yes
 - ☐ No
2. Does the Provider offer continuing care at-home contracts that provide for skilled nursing services?
 - ☐ Yes
 - ☐ No
3. How are these services provided? Select all that apply.
 - ☐ On site at a Facility owned by the Provider
 - ☐ On site at a facility owned by an affiliate
 - ☐ On site by an unaffiliated provider
 - ☐ Off site by at a Facility owned by the Provider
 - ☐ Off site at a facility owned by an affiliate
 - ☐ Off site by an unaffiliated provider
4. Upload a copy of the nursing provider's most recent license renewal and nursing home rating.

If the skilled nursing facility is owned by the Provider, does it participate in the following:

5. Medicare
 - ☐ Yes. If yes, Annual Receipts _____
 - ☐ No
6. Medicaid
 - ☐ Yes. If yes, Annual Receipts _____
 - ☐ No

Assisted Living/Memory Care

7. Do the Provider's continuing care contracts provide for assisted living or memory care services?
 - ☐ Yes
 - ☐ NoIf yes, please provide the following:
 - a. The name of the assisted living provider. _____
 - b. Is the assisted living provider an affiliate of the Provider?
 - ☐ Yes
 - ☐ No
8. Does the Provider offer continuing care at-home contracts that provide for assisted living or memory care services?
 - ☐ Yes
 - ☐ No
9. How are these services provided? Select all that apply.
 - ☐ On site at a Facility owned by the Provider
 - ☐ On site at a facility owned by an affiliate
 - ☐ On site by an unaffiliated provider
 - ☐ Off site by at a Facility owned by the Provider
 - ☐ Off site at a facility owned by an affiliate
 - ☐ Off site by an unaffiliated provider

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10. Upload a copy of the assisted living provider's most recent license renewal.

11. Does this facility require long-term care insurance, Medicare supplement insurance, or similar types of insurance policies on behalf of the residents or the facility? Check all that apply.

- ☐ No
- ☐ Long-term care insurance
- ☐ Medicare supplement insurance
- ☐ Other: a. _____

12. Does this facility arrange long-term care insurance, Medicare supplement insurance, or similar types of insurance policies on behalf of the residents or the facility? Check all that apply.

- ☐ No
- ☐ Long-term care insurance
- ☐ Medicare supplement insurance
- ☐ Other: a. _____

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UNIT ANALYSIS

Please complete the table below regarding the units at the Facility. For the purposes of completing the Unit Analysis, please refer to the descriptions below.

Continuing Care Units: Units, other than Skilled Nursing Units, occupied by or to be occupied by at least one continuing care contract holder. Units that are *Available to Market and Unsold* or *Unavailable to Market* should be reported in this section, rather than the Rental Units section, unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Assisted Living and Memory Care Units: For lines 2, 7 and 15, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date. For lines 3, 8, and 16, please report the number of units that the Provider considers to be Memory Care Units as of the reporting date. If the Provider does not make a distinction between Assisted Living and Memory Care, please report all units as Assisted Living in lines 2, 7, and 15, and enter 0s for lines 3, 8, and 16.

Rental Units: Rental Units are those occupied by individuals who are not continuing care contract holders. *Available to Market and Unsold* and *Unavailable to Market Units* should be reported as Continuing Care Units unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Skilled Nursing Units: Community Beds refers to Skilled Nursing Units occupied by or available to individuals who are not continuing care contract holders. Sheltered Beds refers to Skilled Nursing Units occupied by or available only to continuing care contract holders.

Other Continuing Care Contracts: This section refers to continuing care contract holders residing at a location that is not operated by the Provider. Line 14 refers to individuals with continuing care at-home contracts that are not currently residing at the Facility. Lines 15 through 19 refer to continuing care or continuing care at-home contract holders residing at a location that is not operated by the Provider.

	A Occupied or Sold	B Available to Market and Unsold	C Unavailable to Market	D Reserved by Prospective Residents	E Total (A+B+C+D)
Continuing Care Units					
1. Independent Living Units					
2. Assisted Living					
3. Memory Care					
4. Total Assisted Living (Line 2 + Line 3)					
5. Total Continuing Care Units (Line 1 + Line 4)					
Rental Units					
6. Independent Living Rental					
7. Assisted Living Rental					
8. Memory Care Rental					
9. Total Assisted Living Rental (Line 7 + Line 8)					
10. Total Rental Units (Line 6 + Line 9)					
Skilled Nursing Units					
11. Community Beds					
12. Sheltered Beds					
13. Total Skilled Nursing Beds (Line 11 + Line 12.)					
Other Continuing Care Contracts					
14. Independent Living					
15. Assisted Living					
16. Memory Care					

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17. Total Assisted Living (Line 15 + Line 16)					
18. Skilled Nursing					
19. Total Other Continuing Care Contracts (Sum of Lines 14, 17, and 18)					
20. Total of All Units (Sum of Lines 5, 10, 13, and 19)					

UNIT SALES

	Number
1. Total CCRC units available beginning of this period:	
2. Plus units returned to inventory due to cancellation of sale, death, transfer, move-out, etc. this period:	
3. Plus units added during this period:	
4. Less CCRC units sold this period:	()
5. Less CCRC units removed from inventory for renovation, rental, or other purposes during this period:	()
6. Total CCRC units available end of this period: (Sum of lines 1, 2, and 3, minus lines 4 and 5)	

WAITING LIST

Complete the table below regarding waiting list deposits. A waiting list deposit is any payment made by or on behalf of a prospective resident to a Provider in return for a preferential right to subscribe to a continuing care agreement.

	A Number	B Amount
1. Deposits on hand beginning of this period:		
2. Deposits received this period:		
3. Less Deposits utilized or returned this period:	()	()

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4.	Net deposits on hand end of this period: (Sum of lines 1 and 2, minus line 3)		

RESERVATION DEPOSITS

A reservation deposit is a payment made by or on behalf of a prospective resident for the purpose of reserving a specific unit in a Facility.

	A Number	B Amount
1.	Deposits on hand beginning of this period:	
2.	Deposits received this period:	
3.	Less Deposits utilized or returned this period:	() ()
4.	Net deposits on hand end of this period: (Sum of lines 1 and 2, minus line 3)	

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ENTRANCE FEE CASH SUMMARY REPORT

1. Total Entrance Fees Collected this period: (Include all initial entrance fee deposits and installments collected):		
	A Number	B Amount
2. Beginning Refunds Due		
3. Refunds Incurred this Period		
4. Refunds Paid this Period	()	()
5. Refunds Due End of Period (Sum of lines 2 and 3, minus line 4)		
Refund Balances at End of Period (Aging)	A Number	B Amount
6. Less than 30 Days		
7. 30 - 60 Days		
8. 61 - 90 Days		
9. 91 - 120 Days		
10. * Over 120 Days		
11. TOTAL (Must agree with Line 5 above) (Sum of lines 6 through 10)		

12. Please provide an explanation for any refunds that are unpaid but have been due for more than 120 days.

13. For refunds paid during this reporting period for contracts terminated by residents, please provide the average number of days from the time a resident's contract was terminated and their unit was vacated until the date their refund was issued. _____

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**PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS		
1.	Cash and Cash Equivalents – Unrestricted	
2.	Short-Term Investments – Unrestricted	
3.	Accounts Receivable, Net	
4.	Entrance Fees Receivable	
5.	Other Receivables	
6.	Current Portion Assets Limited as to Use:	
a.	Excess of Minimum Liquid Reserve Funds	
b.	Other Assets Limited as to Use	
7.	Prepaid Expenses	
8.	Other Current Assets	
9.	TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS		
10.	Investments – Restricted	
11.	Assets Limited as to Use:	
a.	Required Minimum Liquid Reserve	
b.	Debt Service Reserve – Held by Trustee	
c.	Other Funds – Held by Trustee	
d.	Other – Not Held by Trustee	
e.	Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12.	Unrestricted Investments	
13.	Property, Plant, and Equipment	
a.	Less Accumulated Depreciation	()
14.	Other	
15.	TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16.	TOTAL ASSETS (Line 9 plus Line 15)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17.	Accounts Payable
18.	Accrued Expenses
19.	Accrued Interest
20.	Current Portion of Entrance Fee Refunds Payable
21.	Current Portion of Long-Term Debt:
a.	On Facility
b.	Other
22.	Current Portion of Notes Payable
23.	Other Short Term Liabilities
24.	TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)
NON-CURRENT LIABILITIES	
25.	Long-Term Debt:
a.	On Facility
b.	Other
26.	Notes Payable
27.	Refundable Entrance Fees
28.	Deferred Revenue from Entrance Fees
29.	Other Long Term Liabilities
30.	TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)
31.	TOTAL LIABILITIES (Line 24 plus Line 30)
NET ASSETS (DEFICIT) / EQUITY	
32.	Beginning Net Assets (Deficit) / Equity
33.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)
34.	Other Contributions or Adjustments
35.	TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)
36.	TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES	
1. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2. Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3. Cash Provided (Used) by Operations:	
a. Entrance Fees Received	
b. Entrance Fee Refunds Paid	()
c. Earned Entrance Fees	()
d. Depreciation	
e. Amortization	
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n. Total Operations Adjustments (Sum of Lines A3a through A3m)	
4. Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES	
1. Change in Investments and Assets Limited as to Use	
2. Purchase of Property and Equipment	
3.	
4.	
5. Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES	
1. Repayment of Long Term Debt	()
2. Entrance Fees Refunded	
3.	
4.	
5.	
6. Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS	
1. Cash and Cash Equivalents – Unrestricted	
2. Short-Term Investments – Unrestricted	
3. Accounts Receivable, Net	
4. Entrance Fees Receivable	
5. Other Receivables	
6. Current Portion Assets Limited as to Use:	
a. Excess of Minimum Liquid Reserve Funds	
b. Other Assets Limited as to Use	
7. Prepaid Expenses	
8. Other Current Assets	
9. TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS	
10. Investments – Restricted	
11. Assets Limited as to Use:	
a. Required Minimum Liquid Reserve	
b. Debt Service Reserve – Held by Trustee	
c. Other Funds – Held by Trustee	
d. Other – Not Held by Trustee	
e. Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12. Unrestricted Investments	
13. Property, Plant, and Equipment	
a. Less Accumulated Depreciation	()
14. Other	
15. TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16. TOTAL ASSETS (Line 9 plus Line 15)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES	
2. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2. Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3. Cash Provided (Used) by Operations:	
a. Entrance Fees Received	
b. Entrance Fee Refunds Paid	()
c. Earned Entrance Fees	()
d. Depreciation	
e. Amortization	
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n. Total Operations Adjustments (Sum of Lines A3a through A3m)	
4. Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES	
1. Change in Investments and Assets Limited as to Use	
2. Purchase of Property and Equipment	
3.	
4.	
5. Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES	
1. Repayment of Long Term Debt	()
2. Entrance Fees Refunded	
3.	
4.	
5.	
6. Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

EXHIBIT A – INTERROGATORIES

For any “Yes” responses, please upload an explanation and any required documentation into the filing. The supporting documentation should be uploaded as a Miscellaneous Document. Please label the documentation appropriately for ease of reference when reviewing the filing.

1. If the Provider is a limited partnership, has the general partner changed since the last filing submission?
 - ☐ Yes
 - ☐ No
2. Has any individual or entity assumed ownership or possession of or control over 10% or more of the Provider, a controlling company of the Provider, or the Provider’s assets, based on the balance sheet from the most recent audited financial report filed with the Office, since the last filing submission?
 - ☐ Yes
 - ☐ No
3. Have there been any other changes in the officers, directors, shareholders of the Provider since the last filing submission?
 - ☐ Yes
 - ☐ No
4. Have there been any changes to managers of or management company for the Facility, including the Executive Director, Facility Administrator, or equivalent position, since the last filing submission?
 - ☐ Yes
 - ☐ No
5. Have there been any changes to the Provider’s organizational structure since the last filing submission?
 - ☐ Yes
 - ☐ No
6. Have there been any changes to the Provider’s organizational documents since the last filing submission? Organizational documents include but are not limited to: articles of incorporation, by-laws, partnership agreement, articles of association, trust agreement, etc.
 - ☐ Yes
 - ☐ No
7. Have any judgments or fines been entered against the Provider since the last filing submission?
 - ☐ Yes
 - ☐ No
8. With respect to any business operations of the Provider, have any bankruptcy, delinquency, receivership, foreclosure or loan default proceedings been initiated since the last filing submission?
 - ☐ Yes
 - ☐ No
9. Is the Provider out of compliance with any terms, conditions, or covenants established in lending agreements for long-term financing?
 - ☐ Yes
 - ☐ No

Facility Name:
Period Ending:

10. Since the last filing submission, have any administrative actions been initiated against any of the following:
- the Provider or any of its officers, directors, or controlling persons;
 - any affiliates of the Provider;
 - the managers or management company of the Facility, including the Executive Director, Facility Administrator, or equivalent position; or
 - any entity providing shelter, nursing care, or personal services pursuant to the Provider's continuing care contracts.
- ☐ Yes
☐ No
11. Since the last filing was submitted, have any of individuals described below been convicted of or pled nolo contendere to a crime, other than a minor traffic violation:
- any officer, director, or controlling person of the Provider; or
 - any managers of the Facility, including the Executive Director, Facility Administrator, or equivalent positions; or
 - any employees or principals of the Facility's management company performing roles similar to those listed above.
- ☐ Yes
☐ No
12. During the reporting period or at any time since the last filing submission, has the Provider failed to pay its obligations as they come due in the normal course of business? For the purposes of this question, "the normal course of business" is defined as the time agreed upon by the involved parties.
- ☐ Yes
☐ No
13. If the answer is yes to item 12, please select all applicable creditor types that the Provider was or is unable to pay timely.
- ☐ Residents or prospective residents (refunds)
 - ☐ Health care providers
 - ☐ Prescription drug vendors
 - ☐ Food vendors
 - ☐ Lenders
 - ☐ Employees
 - ☐ Contract employees or consultants
 - ☐ Construction, maintenance, or similar companies
 - ☐ Insurers
 - ☐ Local, state, or federal government entities (taxes, fees)
 - ☐ Other:
14. Has the Provider closed on any new financing, additional financing, or refinancing since the last filing submission?
- ☐ Yes
☐ No

Facility Name:
Period Ending:

EXHIBIT B – DETAILED LISTING OF THE ASSETS MAINTAINED IN THE MINIMUM LIQUID RESERVES

Please complete and upload the Exhibit B spreadsheet to provide the detailed listing of the assets maintained in the minimum liquid reserves, as required by Section 651.026, Florida Statutes.

EXHIBIT C – PROPERTY, PLANT, AND EQUIPMENT HAVING AN ORIGINAL COST OF \$25,000 OR GREATER

Please complete and upload the Exhibit C spreadsheet to provide the information about Property, Plant, and Equipment having an original cost of \$25,000 or greater, as required by Section 651.026, Florida Statutes. Please note that one sheet in Exhibit C must be completed for Property, Plant, and Equipment Used in Providing Continuing Care, and one sheet must be completed for Property, Plant, and Equipment Not Used in Providing Continuing Care.

EXHIBIT D – LIST OF OFFICERS, DIRECTORS, AND KEY PERSONNEL

Complete the following for all officers, directors, partners, members, and Facility executive director/administrators. Include shareholders and affiliates holding at least 10% interest in the operations of the Provider. State the percentage owned. If such person and/or shareholder has been appointed, elected, nominated, designated or has been added to this list during this report period, place a check in the "New" column provided. If required biographical information has not been previously submitted on those checked, please refer to the instructions provided at <http://www.floir.com/siteDocuments/OfficeDirector.pdf>.

Name	Title/Position	Ownership Percentage	New (select yes or no)	Date of Change

Period Ending:

EXHIBIT E – LIST OF COMPANIES

Complete the following for all companies and affiliates holding at least 10% interest in the operations of the Provider. State the percentage owned. If such company has been added to this list during this report period, select "Yes" in the "New" column provided.

[illegible]

SCHEDULE A – MINIMUM LIQUID RESERVES FOR FACILITIES WITH FINANCING

- Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE B.
 - Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE B and are not required to complete this schedule.
1. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve (“MLR”) Calculation, Form OIR-A3-477, (“MLR Calculation”) filed for the Provider’s current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider’s Annual Report is due, which is 181 days after the end of the Provider’s fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year begins 61 days after the recalculation of the MLR is filed and ends 60 days after the Provider’s annual statement is due, which is 180 days after the last day of the Provider’s fiscal year.
 2. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider’s minimum liquid reserves.
 - a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.
 - b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1b, 1c, 3b, 3c, 5e, or 5f, as applicable.
 - c. If the Provider commingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 651.033, Florida Statutes, the Provider may allocate the balance(s) between Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable. However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.
 - d. If the Provider has a debt service reserve established pursuant to a trust indenture or mortgage lien on the facility, it may be included in Lines 1d and 1e if the Provider has filed the documents specified in Section 651.035(1)(b), Florida Statutes, with the Office. The sum of Lines 1dB and 1eB cannot exceed the Allowable Amount specified in Column 74, Schedule VII, number 74 of the Minimum Liquid Reserve Calculation,
 3. Funds included in the Provider’s MLR are recorded in Lines 6a and 11a of the Facility’s Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility’s Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
Total Trustee Held Debt Service Reserve Funds:		
d.		
e.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Sum of Lines 3a and 3b)		
5. Renewal & Replacement Reserve		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5d)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

Facility Name:
Period Ending:

SCHEDULE B – MINIMUM LIQUID RESERVES FOR FACILITIES WITHOUT FINANCING

- Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE A.
 - Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE A and are not required to complete this schedule.
1. Calculating the Debt Service Reserve - Tax Reserve Requirement
 - a. Annual Property Tax Liability as indicated in the most recent tax notice provided pursuant to s. 197.322(3)
 - b. $1.a / 12 =$ Monthly Tax Reserve Deposit Amount
 - c. Date the Property Taxes were paid:
 - d. $(\text{number of months since property taxes were paid}) \times 1.b =$ Line 1A below.
 2. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve ("MLR") Calculation, Form OIR-A3-477, ("MLR Calculation") filed for the Provider's current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider's Annual Report is due, which is 181 days after the end of the Provider's fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year begins 61 days after the recalculation of the MLR is filed and ends 60 days after the Provider's annual statement is due, which is 180 days after the last day of the Provider's fiscal year.
 3. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider's minimum liquid reserves.
 - a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.
 - b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable.
 - c. If the Provider commingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 651.033, Florida Statutes, the Provider may allocate the balance(s) between Lines However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.
 4. Funds included in the Provider's MLR are recorded in Lines 6a and 11a of the Facility's Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility's Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Sum of Lines 3a and 3b)		
5. Renewal & Replacement Reserve		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5e)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

Facility Name:

Period Ending:

SCHEDULE C – ANNUAL CALCULATION OF FINANCIAL AND OPERATING RATIOS

If the Provider has long-term debt on the Facility and the structure of such debt establishes an Obligated Group, complete SCHEDULE D instead of this schedule.

Preliminary Questions:

1. Has the Provider reached stabilized occupancy?
 - ☐ Yes
 - ☐ No
2. Has the time projected to achieve stabilized occupancy, as reported in the last feasibility study required by the Office as part of an application filing under s. 651.0215, s. 651.023, s. 651.024, or s. 651.0246, elapsed?
 - ☐ Yes
 - ☐ No
 - a. If yes, on what date was the Provider projected to reach stabilized occupancy? _____

I. Days Cash on Hand

1. Please complete the schedules below. Assets are recorded on the Facility Balance Sheet, and Expenses are recorded on the Facility Statement of Operations. Amounts reported below should match the Financial Statements' lines referenced and the amounts reported in the audited financial statements submitted by the Provider with this Annual Report. Lines 1 through 13 will prepopulate based on the Facility Financial Statements in this filing. If the Provider overwrites any of the prepopulated totals, please submit an explanation of the discrepancy.

Assets	Balance as of the Reporting Date
1. Unrestricted cash (Line 1)	
2. Unrestricted short-term investments (Line 2)	
3. Unrestricted long-term investments (Line 12)	
4. Provider restricted funds (Sum of Lines 10 and 11b-d)	
5. Minimum liquid reserve (Line 11a)	
6. Excess of minimum liquid reserve (Line 6a)	
7. Days Cash on Hand Numerator (Sum of 1 through 6)	

2. Please complete the schedules below. Line items should match the Annual Financial Statements and the Audited Financial Statements submitted by the Provider with this Annual Report.

Expenses	Total as of the Reporting Date
8. Operating Expenses (Line 27)	
9. (Depreciation) (Line 25)	()
10. (Amortization) (Line 24)	()
11. (Other Noncash Expenses) (Line 26)	()
12. Adjusted Expense Total (Sum of Lines 8 through 11)	
13. Days Cash on Hand Denominator (Line 12 divided by 365)	

3. Days Cash on Hand (Line 7 above divided by Line 13 above) = _____
4. Is a demand note or other parental guarantee included as a short-term or long-term investment for the calculation above?
 - ☐ Yes
 - ☐ No

Facility Name:
Period Ending:

- a. If yes, please complete the following table. Please provide the Filing ID for the filing number in which the Provider requested to approval to include the demand note or parental guarantee in the days cash on hand calculation. provide the following:

Legal Name of Issuing Entity	Demand Note (select yes or no)	Parental Guarantee (select yes or no)	Amount	Filing ID

- b. Please provide the total amount of all demand notes issued by the parent. _____
- c. Please upload an attachment to the filing that demonstrates that the total amount of all demand notes issued by the parent do not exceed the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent. The attachment should include a certification by an officer of the parent that the documentation provided is true and correct.
5. Do lenders require the Provider to maintain a minimum number of Days Cash on Hand pursuant to the Provider's financing agreements?
- ☐ Yes
- ☐ No
- a. If yes, what is the number of days cash on hand required. _____
- b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Days Cash on Hand as of the reporting date. _____

Facility Name:
Period Ending:

II. Occupancy

Occupancy means the total number of occupied independent living units, assisted living/memory care units, and skilled nursing beds in a Facility divided by the total number of units and beds in that Facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

1. The Facility's occupancy averaged over the 12-month period immediately preceding the reporting date is: _____
2. Please select the basis on which occupancy percentage was calculated:
 - ☐ On a daily basis—average of 365
 - ☐ On a weekly basis—average of 52
 - ☐ On a monthly basis—average of 12

Please note that the Provider should retain all data necessary for the Office or an auditor to verify this calculation.

- 3 Do lenders require the Provider to maintain an occupancy ratio pursuant to the Provider's financing agreements?
 - ☐ Yes
 - ☐ No
 - a. If yes, what is the required occupancy ratio? _____
 - b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's occupancy as of the reporting date. _____

Facility Name:
Period Ending:

III. Debt Service Coverage Ratio

1. Does the Provider have debt on the Facility?

- ☐ Yes
- ☐ No

2. Please complete the schedule below. Line items should match the Facility Financial Statements in this report and the audited financial statements.

Expenses	Total as of the Reporting Date
1. Total Expenses (Line 27)	
2. (Interest Expense on Debt Facility) (Line 16)	()
3. (Depreciation) (Line 25)	()
4. (Amortization) (Line 24)	()
5. (Other Noncash Expenses) (Line 26)	()
6. Adjusted Expense Total (Sum of Lines 1 through 5)	

3. Please complete the schedule below. Line items should match the Facility Financial Statements in this report and the audited financial statements.

Revenues	Total as of the Reporting Date
7. Total Revenues (Line 11)	
8. (Earned Entrance Fees) (Line 5)	()
9. (Other Noncash Revenue) (Line 8)	()
10. (Nonoperating Gains) (Sum of Lines 6, 7, and 9)	()
11. Gross Entrance Fees (Line 3a)	
12. (Refunds Paid) (Sum of Lines 3b and C2)	()
13. Adjusted Revenue Total (Sum of Lines 7 through 12)	

4. Please complete the schedule below. Line items should match the Facility Financial Statements in this report and the audited financial statements.

Debt Service	Total for the 12-Month Period Ending on the Reporting Date
14. Principal (Line 42A, page 10)	
15. Interest (Line 42B, page 10)	
16. Debt Service Denominator (Sum of Lines 14 and 15)	

3. Debt Service Coverage Ratio ((Line 13 above minus Line 6 above) divided by Line 16 above) = _____

4. Do lenders require the Provider to maintain a debt service coverage ratio pursuant to the Provider's financing agreements?

- ☐ Yes
- ☐ No

a. If yes, what is the required debt service coverage ratio. _____

b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Debt Service Coverage Ratio as of the reporting date. _____

Facility Name:
Period Ending:

IV. Additional Information Regarding Financial and Operating Ratios

	Lender Requirement	Lender Calculation	Statutory Requirement	Provider's Ratio	Meets Threshold <i>(the form will prepopulate with yes or no based on the information provided)</i>
Days Cash on Hand	<i>(Populate with Line 5a, Page 43 or NA)</i>	<i>(Populate with Line 5b, Page 41 or NA)</i>	100	<i>(Populate with Line 3, Page 42)</i>	
Occupancy	<i>(Populate with Line 3a, Page 44 or NA)</i>	<i>(Populate with Line 3b, Page 44 or NA)</i>	80%	<i>(Populate with Line 1, Page 44)</i>	
Debt Service Coverage Ratio	<i>(Populate with Line 6, Page 45 or NA)</i>	<i>(Populate with Line 6b, Page 45 or NA)</i>	1.20:1	<i>(Populate with Line 4, Page 45)</i>	

1. If a Provider falls below two or more of the thresholds set forth in Section 651.011(25), Florida Statutes, a Regulatory Action Level Event has occurred. Please file a Corrective Action Plan with the Office as a Periodic Filing through the iPortal within 30 days. Please see Rule 69O-193.066, Florida Administrative Code, for additional information regarding corrective action plans, and Section 651.034, Florida Statutes, for additional information regarding Regulatory Action Level Events.
2. Pursuant to Section 651.011(15)(b), Florida Statutes, beginning January 1, 2021, a Provider is impaired if:
 - a. The Provider has mortgage financing from a third-party lender or a public bond issue, and the Provider's debt service coverage ratio is less than 1.00:1 and the Provider's days cash on hand is less than 90; or
 - b. The Provider's days cash on hand is less than 90 if the Provider does not have mortgage financing from a third party lender or a public bond issue.

If the ratios in this schedule reflect an impairment, please upload an attachment to the filing explaining if there is a reasonable expectation that the impairment may be eliminated within 180 days.

Please see Section 651.1065, Florida Statutes, regarding soliciting or accepting new continuing care contracts by impaired or insolvent Providers.

Facility Name:
Period Ending:

SCHEDULE D – OBLIGATED GROUPS

ANNUAL CALCULATION OF FINANCIAL AND OPERATING RATIOS AND SUPPORTING FINANCIAL INFORMATION FOR OBLIGATED GROUPS

Use this schedule, not SCHEDULE C, if the Provider has long-term debt on the Facility and the structure of such debt establishes an Obligated Group.

1. Provide the Florida Company Code for all Facilities in the Obligated Group who hold Certificates of Authority issued by the Office below, separated by commas.

2. List all other entities that are members of the Obligated Group.

3. Complete Schedules D(1) and D(2). The Provider must make available all necessary records to verify the information reported in this schedule.

4. The first time this Schedule is completed upload financing documents evidencing the members of Obligated Group, terms and conditions of the financing, any bond covenants or other necessary lender requirements, and other documents as necessary to evidence the financing transaction as an attachment to this filing.

5. If any of the terms and conditions of the financing change after the initial filing, please upload any revised documents, amendments, etc. to as an attachment to the this filing.

6. Has the lender determined that the Obligated Group is out of compliance with any terms, conditions, or covenants of its financing agreement?

- ☐ Yes
- ☐ No

- a. If Yes, please upload a document explaining the issue and the steps the Obligated Group is taking to come into compliance.

Facility Name:
Period Ending:

**SCHEDULE D(1) – OBLIGATED GROUP FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS		
1.	Cash and Cash Equivalents – Unrestricted	
2.	Short-Term Investments – Unrestricted	
3.	Accounts Receivable, Net	
4.	Entrance Fees Receivable	
5.	Other Receivables	
6.	Current Portion Assets Limited as to Use:	
a.	Excess of Minimum Liquid Reserve Funds	
b.	Other Assets Limited as to Use	
7.	Prepaid Expenses	
8.	Other Current Assets	
9.	TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS		
10.	Investments – Restricted	
11.	Assets Limited as to Use:	
a.	Required Minimum Liquid Reserve	
b.	Debt Service Reserve – Held by Trustee	
c.	Other Funds – Held by Trustee	
d.	Other – Not Held by Trustee	
e.	Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12.	Unrestricted Investments	
13.	Property, Plant, and Equipment	
a.	Less Accumulated Depreciation	()
14.	Other	
15.	TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16.	TOTAL ASSETS (Line 9 plus Line 15)	

Facility Name:
Period Ending:

**OBLIGATED GROUP FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**OBLIGATED GROUP FINANCIAL STATEMENTS
STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**OBLIGATED GROUP FINANCIAL STATEMENTS
STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES		
1.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2.	Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3.	Cash Provided (Used) by Operations:	
a.	Entrance Fees Received	
b.	Entrance Fee Refunds Paid	()
c.	Earned Entrance Fees	()
d.	Depreciation	
e.	Amortization	
f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		
n.	Total Operations Adjustments (Sum of Lines A3a through A3m)	
4.	Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES		
1.	Change in Investments and Assets Limited as to Use	
2.	Purchase of Property and Equipment	
3.		
4.		
5.	Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES		
1.	Repayment of Long Term Debt	()
2.	Entrance Fees Refunded	
3.		
4.		
5.		
6.	Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

SCHEDULE D(2) – ANNUAL OBLIGATED GROUP FINANCIAL AND OCCUPANCY RATIOS

If the Provider has long-term debt on the Facility and the structure of such debt does not establish an Obligated Group, please complete SCHEDULE C instead of this schedule.

I. Days Cash on Hand

1. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Assets	Balance as of the Reporting Date
1. Unrestricted cash (Line 1)	
2. Unrestricted short-term investments (Line 2)	
3. Unrestricted long-term investments (Line 12)	
4. Provider restricted funds (Sum of Lines 10 and 11b through 11d)	
5. Minimum liquid reserve (Line 11a)	
6. Excess of minimum liquid reserve (Line 6a)	
7. Days Cash on Hand Numerator (Sum of Lines 1 through 6)	

2. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Expenses	Total as of the Reporting Date
8. Operating Expenses (Line 27)	
9. (Depreciation) (Line 25)	()
10. (Amortization) (Line 24)	()
11. (Other Noncash Expenses) (Line 26)	()
12. Adjusted Expense Total (Sum of Lines 8 through 11)	
13. Days Cash on Hand Denominator (Line 12 divided by 365)	

3. Days Cash on Hand (Line 7 above divided by Line 13 above) = _____
4. Is a demand note or other parental guarantee included as a short-term or long-term investment for the calculation above?
 - ☐ Yes
 - ☐ No
 - a. If yes, please complete the following table. Please provide the Filing ID for the filing number in which the Provider requested to approval to include the demand note or parental guarantee in the days cash on hand calculation. provide the following:

Legal Name of Issuing Entity	Demand Note (select yes or no)	Parental Guarantee (select yes or no)	Amount	Filing ID

Facility Name:

Period Ending:

- b. Please provide the total amount of all demand notes issued by the parent. _____
 - c. Please upload an attachment to the filing that demonstrates that the total amount of all demand notes issued by the parent do not exceed the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent. The attachment should include a certification by an officer of the parent that the documentation provided is true and correct.
5. Do lenders require the Obligated Group to maintain a minimum number of Days Cash on Hand pursuant to its financing agreements?
- ☐ Yes
 - ☐ No
- a. If yes, what is the number of days cash on hand required. _____
 - b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Days Cash on Hand as of the reporting date. _____

Facility Name:
Period Ending:

II. Occupancy

Occupancy means the total number of occupied independent living units, assisted living/memory care units, and skilled nursing beds in a Facility divided by the total number of units and beds in that Facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

1. The Facility's occupancy averaged over the 12-month period immediately preceding the reporting date is: _____
2. Please select the basis on which occupancy percentage was calculated:
 - ☐ On a daily basis—average of 365
 - ☐ On a weekly basis—average of 52
 - ☐ On a monthly basis—average of 12

Please note that the Provider should retain all data necessary for the Office or an auditor to verify this calculation.

- 3 Do lenders require the Obligated Group to maintain an occupancy ratio pursuant to the Obligated Group's financing agreements?
 - ☐ Yes
 - ☐ No
 - a. If yes, what is the required occupancy ratio? _____
 - b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Occupancy as of the reporting date. _____

Facility Name:
Period Ending:

III. Debt Service Coverage Ratio

1. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Expenses	Total as of the Reporting Date
1. Total Expenses (Line 27)	
2. (Interest Expense on Debt Facility) (Line 16)	()
3. (Depreciation) (Line 25)	()
4. (Amortization) (Line 24)	()
5. (Other Noncash Expenses) (Line 26)	()
6. Adjusted Expense Total (Sum of Lines 1 through 5)	

2. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Revenues	Total as of the Reporting Date
7. Total Revenues (Line 11)	
8. (Earned Entrance Fees) (Line 5)	()
9. (Other Noncash Revenue) (Line 8)	()
10. (Nonoperating Gains) (Sum of Lines 6, 7, and 9)	()
11. Gross Entrance Fees (Line 3a)	
12. (Refunds Paid) (Lines 3b plus Line C2)	()
13. Adjusted Revenue Total (Sum of Lines 7 through 12)	

3. Please complete the schedule below. Line items should match the Obligated Group Financial Statements in this filing and any audited financial statements prepared for the Obligated Group. If such audited financial statements are completed, submit when submitting this Annual Report.

Debt Service for Obligated Group	Total for the 12-Month Period Ending on the Reporting Date
14. Principal	
15. Interest	
16. Debt Service Denominator (Sum of Lines 14 and 15)	

4. Debt Service Coverage Ratio ((Line 13 above minus Line 6 above) divided by Line 16 above) = _____
5. Do lenders require the Provider to maintain a debt service coverage ratio pursuant to the Provider's financing agreements?
- ☐ Yes
- ☐ No
- a. If yes, what is the required debt service coverage ratio. _____
6. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Debt Service Coverage as of the reporting date. _____

Facility Name:
Period Ending:

IV. Additional Information Regarding Financial and Operating Ratios

	Lender Requirement	Lender Calculation	Statutory Requirement	Provider's Ratio	Meets Threshold <i>(the form will prepopulate with yes or no based on the information provided and statutory requirements)</i>
Days Cash on Hand	<i>(Populate with Line 5a, Page 55 or NA)</i>	<i>(Populate with Line 5b, Page 55 or NA)</i>	100	<i>(Populate with Line 3, Page 54)</i>	
Occupancy	<i>(Populate with Line 3a, Page 56 or NA)</i>	<i>(Populate with Line 3b, Page 56 or NA)</i>	80%	<i>(Populate with Line 1, Page 56)</i>	
Debt Service Coverage Ratio	<i>(Populate with Line 5a, Page 57 or NA)</i>	<i>(Populate with Line 5b, Page 57 or NA)</i>	1.20:1	<i>(Populate with Line 4, Page 57)</i>	

3. If a Provider falls below two or more of the thresholds set forth in Section 651.011(25), Florida Statutes, a Regulatory Action Level Event has Occurred. Please file a Corrective Action Plan with the Office as a Periodic Filing through the iPortal within 30 days. Please see Rule 69O-193.066, Florida Administrative Code, for additional information regarding corrective action plans, and Section 651.034, Florida Statutes, for additional information regarding Regulatory Action Level Events.
4. Pursuant to Section 651.011(15)(b), Florida Statutes, beginning January 1, 2021, a Provider is impaired if:
 - a. The Provider has mortgage financing from a third-party lender or a public bond issue, and the Provider's debt service coverage ratio is less than 1.00:1 and the Provider's days cash on hand is less than 90; or
 - b. The Provider's days cash on hand is less than 90 if the Provider does not have mortgage financing from a third party lender or a public bond issue.

If the ratios in this schedule reflect an impairment, please upload an attachment to the filing explaining if there is a reasonable expectation that the impairment may be eliminated within 180 days.

Please see Section 651.1065, Florida Statutes, regarding soliciting or accepting new continuing care contracts by impaired or insolvent Providers.

1. If a Provider falls below two or more of the thresholds set forth in Section 651.011(25), Florida Statutes, a Regulatory Action Level Event has Occurred. For a Provider that is a member of an Obligated Group, the Obligated Group's days cash on hand and debt service coverage ratio will be used. Please file a Corrective Action Plan with the Office as a Periodic Filing through the iPortal within 30 days. Please see Rule 69O-193.066, Florida Administrative Code, for additional information regarding corrective action plans, and Section 651.034, Florida Statutes, for additional information regarding Regulatory Action Level Events.
2. Pursuant to Section 651.011(15)(b), Florida Statutes, beginning January 1, 2021, a Provider is impaired if:
 - a. The Provider has mortgage financing from a third-party lender or a public bond issue, and the Provider's debt service coverage ratio is less than 1.00:1 and the Provider's days cash on hand is less than 90; or
 - b. The Provider's days cash on hand is less than 90 if the Provider does not have mortgage financing from a third party lender or a public bond issue.

If the ratios in this schedule reflect an impairment, please upload an attachment to the filing explaining if there is a reasonable expectation that the impairment may be eliminated within 180 days.

Please see Section 651.1065, Florida Statutes, regarding soliciting or accepting new continuing care contracts by impaired or insolvent Providers.



Florida Office of Insurance Regulation

MINIMUM LIQUID RESERVE (MLR) CALCULATION

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

**MINIMUM LIQUID RESERVE CALCULATION
FILED BY**

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

**FOR PERIOD FROM
[MM/DD/YYYY] TO [MM/DD/YYYY]**

**MINIMUM LIQUID RESERVE (MLR) CALCULATION****GENERAL INSTRUCTIONS**

1. A Provider that holds more than one Certificate of Authority issued by the Office must complete and submit an MLR Calculation, including all supporting schedules, for each of its Facilities.
2. Submit this form electronically via the Office's system at <https://www.floir.com/iportal>.
3. Attestation. After completing the required report, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.
4. This form, including all supporting schedules, must be completed and filed each year with the Annual Report, and may be required in the event of additional long-term financing or other occurrences that result in a change to the debt service or leasehold payments due during the fiscal year. Due dates for this form are provided below.
 - If the Provider's fiscal year-end is December 31, this form is due on May 1st.
 - If the Provider's fiscal year-end is not December 31, this form is due within 120 days of the last day of the Provider's fiscal year.
 - For a new Facility commencing operations, an updated version of this form and supporting schedules must be submitted no later than 30 days before the Provider requests the release of moneys held in escrow pursuant to Section 651.023(6), Florida Statutes. The Provider should reference the update to the Minimum Liquid Reserve calculation in the Periodic Filing requesting the release of initial entrance fees. If the Provider is requesting its release of initial entrance fees pursuant to Section 651.023(6), Florida Statutes, before an Annual Report Filing has been made, please submit it in the Periodic Filing requesting the release of funds.
 - For a Facility that has incurred additional financing or for which there has been a change in the aggregate amount of principal, interest, or leasehold payments due during the fiscal year, this form should be filed within 10 days from the date of closing of the new financing or change in the amount of payments due during the fiscal year.
5. In completing the first page of this filing, the "From" date refers to either:
 - the first day of a Provider's fiscal year if the Provider has previously secured release of moneys held in escrow have been released pursuant to Section 651.023(6), Florida Statutes;
 - for a new Facility commencing operations, the date the Provider intends to secure release of moneys held in escrow pursuant to Section 651.023(6), Florida Statutes, or
 - for a Facility that has incurred additional financing or for which there has been a change to the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing or a change to all leasehold payments and all costs relate to such payments, requiring a recalculation of the minimum liquid reserves, 61 days after the updated MLR Calculation is due to be filed.
6. New Facilities. For the first 12 months of operation, each Provider shall maintain in escrow an operating reserve equal to 30 percent of the total operating expenses projected in the feasibility study submitted with the Provider's application for issuance of a Certificate of Authority,
7. Facilities in operation more than 12 months. If a Provider has been in operation for more than 12 months, the total operating expenses is determined using the total operating expenses in the Annual Report. The total annual operating expenses is determined by averaging the total annual operating expenses reported to the Office by the number of annual reports filed with the Office within the preceding 3-year period, subject to adjustment if there is a change in the number of facilities owned.



8. Annualizing amounts. If any year for which revenue or expense data from the Annual Report is required to be used does not represent 12 full months of operation due to a change in fiscal year or a Facility being operational for less than a year, the Provider must provide an annualized amount. To annualize the amount, divide the amount of revenue or expense by the number of months in the short or long fiscal year, then multiply the quotient by 12. When it is necessary to annualize the revenue or expense data, it will be necessary to overwrite the prepopulated amounts.
9. This form is meant to be completed in order, beginning with Schedule I. As you complete the report form, totals will be calculated and subsequent fields will be pre-populated based on your responses. Due to the nature of the MLR Calculation, many of the prepopulated lines cannot be overwritten. If you feel you need to overwrite a prepopulated field, selecting the "highlight fields" box at the top right corner of the screen, will allow you to view which fields can be changed. Selecting the "highlight required fields" box at the top right corner will show all required fields in a red box.
10. Please note that not all schedules apply to every Provider. A cursory review of the instructions for each schedule may save you time in the preparation of this form or alert you to the need for pre-approval by the Office before a specific schedule may be used.
- Schedule I – Required
 - Schedule II – Required
 - Schedule III – Required unless the Facility has been in operation for less than 1 year
 - Schedule IV(A) – Required for Facilities with mortgage loans, leases, or other financing on the Facility.
 - Schedule IV(B) -Required for Facilities without a mortgage loan, lease, or other financing on the Facility.
 - Schedule V - Complete only if Section 651.035(4)(b), F.S., is applicable and the Office approval has been given.
 - Schedule VI(A)- Required
 - Schedule VI(B) – Complete only if monthly minimum liquid reserve required for facilities without mortgage loans, leases, or other financing on the Facility.
 - Schedule VII- Complete only if the Office has approved a reduced debt service reserve pursuant to Section 651.035(2)(b), F.S.
 - Schedule VIII-Complete only if the Office has given prior approval for the use of a letter of credit pursuant to Section 651.035(5), F.S.
 - Schedule IX-Required
11. The Enable Calculations check box (at the top of each page) will allow you to turn the auto calculation feature on or off. Turning off this feature allows for faster data entry, but in order to submit the form, this feature must be enabled to ensure all calculations and validations are correct.
12. The MLR Calculation is subject to review by the Office. The Office will review this calculation and may require amended or revised calculations if there are inconsistencies between this form and other information filed with the Office. Further, the Office may require a Provider to amend or revise this form if it does not approve a Request for Waiver of the Minimum Liquid Reserve or disallows a reduction in debt service reserves pursuant to Section 651.035(2)(b), Florida Statutes.

ATTESTATION

This filing will not be considered complete unless it has been attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by the managing general partner.
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies of this page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)_____
(Title)_____
(Typed Name)_____
(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

☐ _____ who is personally known to me, or☐ _____ who produced the following identification: _____.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)_____
(Signature)_____
(Title)_____
(Typed Name)_____
(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

☐ _____ who is personally known to me, or☐ _____ who produced the following identification: _____.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

MINIMUM LIQUID RESERVE (MLR) CALCULATION
SCHEDULE I
GENERAL INFORMATION

Contact: _____ Contact Title: _____

Phone: _____ Ext: _____

Email Address: _____

1. This MLR Calculation is (select one):

- The Facility's annual MLR Calculation, filed with the Annual Report, as required by Section 651.026(2)(e), Florida Statutes;
- A recalculation of the MLR due to incurred additional financing or for which there has been a change in the aggregate amount of principal, interest, or leasehold payments due during the fiscal year; or
- An updated calculation filed before the initial release of escrowed funds.

2. This calculation is based on (select one):

- Annual Report data for the period ending on _____ and debt service requirements for the one year period following the as-of date of the Annual Report, which is _____ to _____; or
- Feasibility study data and debt service requirements for the current fiscal year which is _____ to _____.

3. Provider's Fiscal Year End: _____

A. Has Provider's fiscal year end changed in the last 3 years? ☐ Check if Yes

i. If Yes, Fiscal year-ending date of short/long fiscal year. _____

ii. If Yes, Number of months in short/long fiscal year. _____

4. For MLR Calculations filed with the Annual Report as required by 651.035(2)(e), Florida Statutes, the MLR Funding year begins 61 days after the Annual Report due date and ends one year later (61 days after the next year's Annual Report is due).

For new Facilities, Providers should enter the date that the Provider intends to secure release of moneys held in escrow pursuant to Section 651.023(6), Florida Statutes, as the beginning date for the MLR funding year.

For recalculations of the MLR based on a Facility incurring additional financing or a change to the aggregate amount of principal, interest, or leasehold payments due during the fiscal year, Providers should enter 61 days from the date this MLR Calculation is due to be filed as the beginning date for the MLR funding year.

The ending date for the MLR funding year is 181 days after the end of the Provider's current fiscal year.

The MLR funding year that applies to this filing is: _____ to _____.

5. Provide the following figures:

- A. The number of continuing care and continuing care at-home residents at this Facility at the end of the most recent fiscal year. If the Facility has been open less than 12 months include the number of sales anticipated by the feasibility study for the MLR period ending date. Double occupancy pursuant to one continuing care contract constitutes two residents. _____
- B. Provide the number of individuals, other than continuing care and continuing care at-home residents, at this Facility at the end of the most recent fiscal year. This includes renters, community patients, and any other individuals who reside at the Facility but are not the subject of a continuing care contract. If the Facility has been open less than 12 months, include the projected number of non-continuing care residents projected in the feasibility study. Double occupancy pursuant to one continuing care contract constitutes two residents. _____

6. Provide the information below regarding historical liability insurance premiums.

- A. Provide the amount of liability insurance premium paid in calendar year 1999 or indicate if the Facility was not operational at that time.
- Not operational in 1999; or
 - Liability premiums in 1999: _____
- B. For Providers receiving a Certificate of Authority for this Facility during or after calendar year 1999, provide the amount of liability insurance premium paid during the first 12 months of operations. If the Facility has been open for less than 12 months, please provide the amount of liability insurance projected in the feasibility study. _____

7. Insurance Expense. Complete one row for each completed fiscal year. The most recently completed fiscal year should be entered as (A), the prior year as (B), and the period two years prior as (C). For a Facility that has been in operation for less than one year, use the insurance expense projected in the feasibility study. For a Facility that has been in operation for more than 12 months but less 3 years, enter data corresponding to each Annual Report that has been filed. Row (D) will compute automatically based on the values entered in Rows (A) through (C).

- A. In Column C, please provide the amount of liability insurance expense paid during each of the MLR reporting years.
- B. In Column D, please provide the amount of insurance expense paid for insurance other than liability insurance and property insurance during each of the MLR reporting years.

		C. Liability Insurance Expenses	D. Insurance Expense Other than Liability and Property Insurance
20	(A)		
20	(B)		
20	(C)		
Average	(D)		

SCHEDULE II
OPERATING EXPENSES FROM THE STATEMENT OF OPERATIONS

Complete one row for each completed fiscal year. The most recently competed fiscal year should be entered as (A), the prior year as (B), and the period two years prior as (C). For a Facility that has been in operation for less than one year, enter the expenses projected in the feasibility study in Row (A). For a Facility that has been in operation for more than 12 months but less 3 years, enter data corresponding to each Annual Report that has been filed. Row (D) is automatically computed by dividing the sum of the Columns (A, B, & C), by the number of completed rows.

Entries in Columns 8 and 9 should agree with the Facility Statement of Operations in the Annual Report. If the MLR Calculation is submitted with the Annual Report, Columns 8 and 9 will pre-populate.

If you report an amount in Column 10A., attach a detailed calculation for the determined amount. This amount must be supported by CPA workpapers.

If you report an amount in Column 10B., attach a detailed summary of expenses. Only extraordinary expenses that are explained and documented in accordance with GAAP may be included.

Column 11 will calculate the difference between the values reported in Column 7C and the values reported in Line 6A. or 6B, as applicable. If the average is negative or 0, no benefit is gained, and Column 11 will be excluded from the calculation of Column 12.

Column 12 is automatically calculated based on Column 8 minus Columns 9 through 11.

		8.	9. Deduct the following expenses:				10.		11.	12.
		Total Expenses (Line 27)	A. Interest (Line 16a)	B. Tax (Line 22)	C. Amortization (Line 24)	D. Depreciation (Line 25)	A. Changes in obligation to provide future services*	B. Extraordinary Expenses*	Extra Insurance Expenses* (Column 7C - Line 6A or 6B)	Net Operating Expenses
20____	(A)	_____	_____	_____	_____	_____	_____	_____	_____	
20____	(B)	_____	_____	_____	_____	_____	_____	_____	_____	
20____	(C)	_____	_____	_____	_____	_____	_____	_____	_____	
Average	(D)	_____	_____	_____	_____	_____	_____	_____	_____	_____

Answer the yes or no questions below. If submitting with an Annual Report, the answers should be as of the last fiscal year-end date. Otherwise, your responses should be as of the date the MLR calculation is submitted. Except for Line 23, the form will automatically complete Lines 13 - 38. Please note that not all lines will be completed.

Has the Facility been in business for 12 months or more?

YesNo

Is the physical plant owned by the Provider?

YesNo

If the Facility has operated **less than 12 months**, the annual operating reserve is calculated below:

$$(13) \times (.30) \times (15) / (16) = (17)$$

- 13. Net Operating Expenses (Line 12D)
- 14. Operating Reserve Factor (.30)
- 15. CCRC Residents (Line 5A)
- 16. Total Residents (Lines 5A + 5B)
- 17. Total Operating Reserve

CALCULATION: _____ X .30 X _____ / _____ = _____

If the Facility has operated for **12 or more months**, the annual operating reserve is calculated below:

$$(18) \times (.15) \times (20) / (21) = (22)$$

- 18. Net Operating Expenses (Line 12D)
- 19. Operating Reserve Factor (.15)
- 20. CCRC Residents (Line 5A)
- 21. Total Residents (Lines 5A + 5B)
- 22. Total Operating Reserve

CALCULATION: _____ X .15 X _____ / _____ = _____

SCHEDULE III
RENEWAL AND REPLACEMENT RESERVE

If the Facility has been in operation **12 or more months and is owned by the Provider**, the Renewal and Replacement Reserve is calculated as follows:

$$(23) \times (.15) \times (25) / (26) = (27)$$

- 23. Total Accumulated Depreciation on plant, property and equipment of the Facility as reported on the most recent audited financial statements.
- 24. RRR Factor (.15)
- 25. CCRC Residents (Line 5A)
- 26. Total Residents (Lines 5A + 5B)
- 27. Total Renewal and Replacement Reserve

CALCULATION: _____ X .15 X _____ / _____ = _____

Statutes limit the renewal and replacement reserve to 15% of a 3-year average of net operating expenses and is calculated as follows:

$$(28) \times (.15) \times (30) / (31) = (32)$$

- 28. Net Operating Expenses (Line 12D)
- 29. Reserve Limiting Factor (.15)
- 30. CCRC Residents (Line 5A)
- 31. Total Residents (Lines 5A + 5B)
- 32. Renewal and Replacement Reserve Limit

CALCULATION: _____ X .15 X _____ / _____ = _____

33. The Lesser of Lines (27) or (32) is your Renewal and Replacement Reserve Requirement.

This section is calculated only if the Facility has been in operation more than 12 months, is operated by but is NOT owned by the Provider, and the Facility's accumulated depreciation is NOT included on the Provider's books, the Renewal and Replacement Reserve limit is calculated as follows:

$$(34) \times (.15) \times (36) / (37) = (38)$$

- 34. Net Operating Expenses (Line 12D)
- 35. Reserve Limiting Factor (.15)
- 36. CCRC Residents (Line 5A)
- 37. Total Residents (Lines 5A + 5B)
- 38. Total Renewal and Replacement Reserve Limit

CALCULATION: _____ X .15 X _____ / _____ = _____

SCHEDULE IV(A) ANNUAL DEBT RESERVE – FACILITIES WITH MORTGAGE LOANS, LEASES, OR OTHER FINANCING ON THE FACILITY

Mortgage Loans, Bond Issues, or Other Long-Term Financing. For Columns 39 through 44, complete a separate line for each mortgage loan, bond issue, or other long-term financing of the Facility during the fiscal year reported in Schedule I, Line 2. Entries should reflect actual or expected debt service expenses applicable to the fiscal year for which the minimum liquid reserve is calculated. If no payments are due this fiscal year, enter 0s in the first line.

Leasehold Payments. For Column 45, record any leasehold payments due during the fiscal year reported in Schedule I, Line 2 and all costs related to such payments. A separate line should be completed for each lease. Entries should reflect actual or expected debt service expenses applicable to the fiscal year for which the minimum liquid reserve is calculated. If no payments are due this fiscal year, enter a 0s in the first line.

Debt Service Reserves. Please note that if a Facility has a debt service reserve account that reserves for only one series of a bond issue, a separate row must be completed for each series of the bond. If the Facility has a debt issue with more than one debt service reserve accounts, a separate row must be entered for each portion of the debt reserved for by the debt service reserve account. For each account that the Provider would like to include in its minimum liquid reserve pursuant to Section 651.035(1)(b), F.S., please check the box next to that debt issue.

Waivers. For waivers approved pursuant to Section 651.035(3), F.S., only enter the amount the Office did not waive. Enter 0s in the first row if all principal and interest requirements were waived.

Property Taxes. All Providers are required to maintain a reserve for property taxes. For facilities with mortgage loans or other long-term financing, a Provider must reserve an amount equal to the amount recorded in its most recent audit. If the Provider’s mortgage loan or other long-term financing does not require a tax payment reserve or does not require the Provider to reserve an amount equal to or exceeding that amount, then the Provider must maintain a tax payment reserve equal in amount for property taxes as recorded in the audited financial report required under 651.026, F.S. Property tax amount should agree with Line 22a Facility Statement of Operations in the Annual Report. If a reserve for property taxes is not included in any of the debt service reserve accounts reported below, please include property taxes in Column 44. on the last row of this schedule.

	39.	40.	41.	42.	43.	44.	45.	46.
Include this debt in Sched VII?	Description of Debt	Date of Financing Agreement	Principal Payments Due	Interest Payments Due	Subtotal Debt Service (41+ 42)	Tax Payment Reserve	Leasehold Payments Due	Total Annual Debt Service (43 + 44 + 45)
☐								
☐								
☐								
☐								
☐								
☐								
	Property Taxes							
	47. Total Sum of Column 46:							

SCHEDULE IV(B) ANNUAL DEBT SERVICE RESERVE – FACILITIES WITHOUT MORTGAGE LOANS, LEASES, OR OTHER FINANCING ON THE FACILITY

Pursuant to Section 651.035(1)(a), F.S., if a Provider does not have a mortgage loan or other financing on the Facility, the Provider must deposit monthly in escrow as a minimum liquid reserve an amount equal to one-twelfth of the annual property tax liability as indicated in the most recent tax notice provided pursuant to Section 197.322(3), F.S., and must annually pay property taxes out of such escrow. Accordingly, the minimum required debt service reserve for the Facility will increase each month until property taxes are paid. The minimum required debt service reserve for each month is calculated below.

48. Annual Property Tax Liability as indicated in the most recent tax notice provided pursuant to Section 197.322(3), F.S., is _____. This is the Annual Debt Service Reserve.

49. The required monthly debt service reserve deposit amount is calculated by dividing the amount reported in Line 48 by 12.

CALCULATION: _____ / 12 = _____

50. The date the Property Taxes were paid is _____.

Please complete the schedule below to determine the minimum required debt service reserve for each month. Line 51 will show the deposit schedule, with each row containing the name of a month, starting with the month in which property taxes were last paid in 51A. After the first month is entered in 51A, the remaining months should automatically populate. Line 52 will prepopulate by multiplying the monthly debt service reserve deposit amount by the number of months since the property taxes were paid. For example, 52A will equal Line 49 times 1 and Line 52G will equal Line 52 times 7.

	A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.
51.												
52.												

SCHEDULE V
REDUCED DEBT SERVICE ALLOWANCE

Complete only if permanently not selling CCRC contracts and approved upon submitting proper request to the Office, pursuant to 651.035(2)(b), F.S. Enter the approval date on Line 53 and the form will calculate Lines 54 through 57.

53. Date of Office's Approval: _____

The Annual Debt Service is calculated as follows:

$$(54) \times (55) / (56) = (57)$$

54. Subtotal Debt Service (Line 47)

55. CCRC Residents (Line 5A)

56. Total Residents (Lines 5A + 5B)

57. Adjusted Total Debt Service

CALCULATION: _____ x _____ / _____ = _____

SCHEDULE VI(A)
MINIMUM LIQUID RESERVE REQUIRED

These lines show the Facility's MLR requirement by component and the total MLR requirement.

58.

Total Annual Debt Service from Schedule IV(A), Line 47,
Schedule IV(B) Line 48, or Schedule V, Line 57, as applicable:.
59.

Total Operating Reserve from Schedule II:
60.

Total Renewal and Replacement Reserve from Schedule III:
61.

Total Annual Minimum Liquid Reserve Requirement:
(Lines 58 + 59 + 60)

SCHEDULE VI(B)

MONTHLY MINIMUM LIQUID RESERVE REQUIRED FOR FACILITIES WITHOUT MORTGAGE LOANS, LEASES, OR OTHER FINANCING ON THE FACILITY

Enter the month in which property taxes were paid below. The table below will populate with the month of payment in the first row with each subsequent month populating below. The second row will populate with the monthly debt service amount from Schedule IV(B). The Monthly MLR Requirement will populate with the sum of the monthly debt service requirement plus the sum of the Total Operating Reserve from Schedule II and the Total Renewal and Replacement Reserve from Schedule III. If a withdraw from the Renewal and Replacement Reserve has been approved that information will be reflected on the Annual, Monthly, or Quarterly financial report, not on this form.

62. Month in which the taxes were paid: _____

Month	Debt Service Reserve Amount	Monthly MLR Requirement

Facility Name:

☒ Enable Calculations

SCHEDULE VII
DEBT SERVICE RESERVE VERIFICATION

This schedule is to assure compliance with the requirements of Section 651.035(1)(b), F.S., identify allowable debt service reserves, and review balance allowances or deficits toward MLR compliance. Complete only if the Provider would like to include funds held in escrow pursuant to a financing agreement in computing its minimum liquid reserves pursuant to Section 651(1)(b), F.S. Providers may only include funds held in escrow that may only be used to pay principal and interest payments on the debt that the Provider is obligated to pay and which may include taxes and insurance. For the purposes of completing this schedule, such funds held in escrow are referred to as a “financing debt service reserve.” To include one or more financing debt service reserve(s), complete a separate line of this schedule for each account. A financing debt service reserve will not be included the Provider’s minimum liquid reserves unless the Provider has furnished a copy of the agreement under which such debt service is held to the Office. If a copy of the agreement has not yet been provided to the Office, please upload a readable PDF of the agreement into this filing. In order for the Office to include the financing debt service reserve in the Provider’s minimum liquid reserves for the next funding year, the Provider must upload a statement of the amount being held in escrow for the financing debt service reserve, certified by the lender or trustee and the Provider to be correct pursuant to Section 651.035(1)(b), F.S., The statement should state that the reserve may only be used for principal and interest and should indicate if property taxes or insurance are included. This statement should be uploaded into the Annual Report filing no later than 61 days after the due date for this MLR Calculation.

If the Provider’s trust indenture allows for payment of property taxes, complete Column 63 by entering the last three years of property insurance expense, Complete one row for each fiscal year completed with (A) being the most recent, (B) the next most recent, and (c) the oldest. For a Facility open less than three years, enter as many years as data is available for or from the feasibility study if the Facility has been open for less than 12 months. beginning with the most recent year first. The average of property insurance expense will be automatically computed in Row (D).

Year		63. Property Insurance Expense
20____	(A)	
20____	(B)	
20____	(C)	
Average	(D)	

The Property Insurance Reserve is calculated as follows: (64) x (65) x (66) / (67) = (68)

64. Average Property Insurance Expense (Line 63D)
65. Reserve Limiting Factor (.15 if Facility has been in business 12 months or more OR .30 if less than 12 months)
66. CCRC Residents (Line 5A)
67. Total Residents (Lines 5A + 5B)
68. Total Property Insurance Reserve

CALCULATION: _____ X _____ X _____ / _____ = _____

Columns 64 and 65 should pre-populate with information provided in Schedule IV(A) if the box to the left of Column 39 has been marked. Columns 67 and 68 compare the financing debt service reserve balances to the debt service reserve requirements in Columns 42, 42, 44 and Line 63 and automatically populates. Column 69 is automatically calculated and indicates the amount in each financing debt service reserve account that may be included in the Provider's minimum liquid reserves for this Facility. **Please note financing debt service reserve funds in excess of the allowable amounts in Column 73 cannot be included in the Provider's minimum liquid reserves for this Facility.**

69.	70.	71.	72. See Description Below *				73.				74.
Description of Debt	Date of Financing Agreement	Date the Financing Agreement Furnished to the Office	(A) Enter Principle Reserve Balance	(B) Enter Interest Reserve Balance	(C) Enter Tax Reserve Balance	(D) Enter Insurance Reserve Balance	(A) Lesser of Column 44 or Column 72A	(B) Lesser of Column 42 or Column 72B	(C) Lesser of Column 44 or Column 72C	(D) Lesser of Line 68 or Column 72D	Total Lender's Debt Service Reserve Allowable Pursuant to Section 651.035(1)(b), F.S. (73A+73B+73C+73D)

**SCHEDULE VIII
USE OF LETTER OF CREDIT FOR
MINIMUM LIQUID RESERVE**

Complete only if a letter of credit approved pursuant to Section 651.035(5), F.S., and the Office, is used to satisfy part of the minimum liquid reserve requirement. Entering a date on line 73 will prompt the form into completing lines 74 - 76. The amount calculated on Line 76 is the minimum cash balance required in your operating reserve regardless of the letter of credit funding amount.

Enter the amount along with the expiration date of the letters of credit.

75. The Date of Approval accepting
the Letter of Credit: _____

The Required Operating Cash Reserve is calculated as follows:

$(\text{Column 72}) \times (.167) = (74)$

76. Total Net Operating Expenses (Line 15D)

77. 2 months / 12 months (.167)

78. Required Operating Cash Reserve

CALCULATION: _____ X .167 = _____

79. Enter the Amount and Expiration Date of all Letter(s) of Credit

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

NOTE: The letter of credit operating cash reserve must be on deposit in an unencumbered MLR escrow account regardless of the letter of credit amount pursuant to Section 651.035(5)(d), F.S. The operating cash reserve cannot be pledged or used as collateral to secure the letter of credit. If the letter of credit expires and does not include automatic renewal language or reprices each year upon recalculation of your MLR, you must submit the original irrevocable letter of credit to and in favor of the Office prior to the funding year (61 days after Annual Report is due).

FURNISH THE FOLLOWING INFORMATION:

SCHEDULE IX ESCROW ACCOUNTS

80. The escrow agent name, address, contact name, title, phone number, and fax number of the escrow agent(s) who has custody of the MINIMUM LIQUID RESERVE escrowed funds, or any funds used to satisfy MINIMUM LIQUID RESERVE requirements.

Escrow Agent	Street Address	City	State/ Prov.	Zip/Postal Code	Contact Name	Title	Phone #	Fax #

81. Provide the name of the lender or trustee, the account number or account numbers and identify each account established for all funds held in escrow pursuant to Section 651.035, F.S. Furnish the unique identifier assigned by the Office to the escrow agreement, the balance as of the fiscal year end with which the calculation is being filed and that date. If the calculation is an initial one, enter the amount and projected funding date that will be transferred into escrow:

Financial Institution or Bank Name	Account Number	Escrow Agreement Unique Identifier	Balance	As Of



Florida Office of Insurance Regulation

MONTHLY FINANCIAL REPORT

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

MONTHLY FINANCIAL REPORT OF

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

FOR PERIOD ENDED

GENERAL INFORMATION AND INSTRUCTIONS

The Florida Office of Insurance Regulation (“Office”) issues a Certificate of Authority to the Provider, which is the legal entity that issues contracts for continuing care for a Facility, including residency agreements, reservation agreements, and waitlist agreements. Separate Certificates of Authority are issued for each Facility, which can result in a single Provider holding multiple Certificates of Authority and, therefore, submitting multiple reports for the same period. In addition to operating multiple Facilities, it is not unusual for Providers to engage in business other than providing continuing care in Florida. As a result, the Office requires financial information at the Provider and Facility level to evaluate the financial condition.

Further, many continuing care Providers are part of holding company structures through which they are affiliated with other Florida Providers through common ownership or control. These instructions are intended to clarify reporting requirements so that the Office has a clear understanding of the participants in the Florida market, regardless of organizational structure.

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
2. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
3. Submit this form electronically via the Office’s system at <https://www.flair.com/iportal>.
4. All questions and portions of this form must be completed in order for the filing to be considered complete—do not leave any items blank. For the financial statements, please ensure to enter 0 for numerical values and N/A for text responses, as appropriate, rather than leaving the field blank.
5. If additional explanations, supporting statements, documentation, or schedules are necessary, please upload them to the filing by attaching them as a Miscellaneous Document. Please add a label to the Miscellaneous Document that describes the attachment for ease of reference. Any attachments should be in a readable electronic format (i.e. Word, Excel, PDF, etc.).
6. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.
7. Financial Statements. Provide a Balance Sheet, Statement of Operations, and Statement of Cash Flows (collectively “Financial Statements”) for both the Facility and the Provider. If operating the Facility is the Provider’s only business, we would expect the Financial Statements for the Provider and Facility to be identical. If the Provider has more than one Facility or is engaged in other business in addition to operating the Facility, we would expect the Facility’s Financial Statements to reflect the financial position and operations of the Facility as a sub-unit of the Provider and the Provider’s Financial Statements to reflect the financial position of the Provider and all of its operations.
8. Minimum Liquid Reserves. Section 651.035, Florida Statutes, establishes minimum liquid reserve requirements that must be maintained by a Provider for each Facility. Minimum liquid reserve (“MLR”) funds must be maintained in escrow or on deposit with the Department of Financial Services, Bureau of Collateral Management. MLR funds are recorded in Lines 6a and 11a of the Balance Sheet.

In addition, Providers shall submit a schedule detailing MLR funding and accounts. Providers with financing on the Facility should complete SCHEDULE A and not SCHEDULE B. Providers without financing on the Facility should complete SCHEDULE B and not SCHEDULE A.

Facility Name:

Period Ending:

9. Escrow Statements. To document compliance with the Minimum Liquid Reserve Requirement, please upload escrow statements as a component of this filing. For the purpose of SCHEDULE A and SCHEDULE B, If a Provider uses a single MLR account for one or more of the Facility's MLR reserves, the Provider should evenly apportion the funds between the appropriate reserve types for completing the MLR schedule.
10. If a Provider owns more than one Facility, or if the Provider is affiliated through common ownership or control with additional Providers owning Facilities in Florida, please include a Provider Group Code on the cover page for the monthly, quarterly, and annual filings.

Facility Name:
Period Ending:

ATTESTATION

This filing will not be considered complete unless it has attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies the page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20_____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20_____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

Facility Name:
Period Ending:

UNIT ANALYSIS

Please complete the table below regarding the units at the Facility. For the purposes of completing the Unit Analysis, please refer to the descriptions below.

Continuing Care Units: Units, other than Skilled Nursing Units, occupied by or to be occupied by at least one continuing care contract holder. Units that are *Available to Market and Unsold* or *Unavailable to Market* should be reported in this section, rather than the Rental Units section, unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Assisted Living and Memory Care Units: For lines 2, 7 and 15, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date. For lines 3, 8, and 16, please report the number of units that the Provider considers to be Memory Care Units as of the reporting date. If the Provider does not make a distinction between Assisted Living and Memory Care, please report all units as Assisted Living in lines 2, 7, and 15, and enter 0s for lines 3, 8, and 16.

Rental Units: Rental Units are those occupied by individuals who are not continuing care contract holders. *Available to Market and Unsold* and *Unavailable to Market Units* should be reported as Continuing Care Units unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Skilled Nursing Units: Community Beds refers to Skilled Nursing Units occupied by or available to individuals who are not continuing care contract holders. Sheltered Beds refers to Skilled Nursing Units occupied by or available only to continuing care contract holders.

Other Continuing Care Contracts: This section refers to continuing care contract holders residing at a location that is not operated by the Provider. Line 14 refers to individuals with continuing care at-home contracts that are not currently residing at the Facility. Lines 15 through 19 refer to continuing care or continuing care at-home contract holders residing at a location that is not operated by the Provider.

	A Occupied or Sold	B Available to Market and Unsold	C Unavailable to Market	D Reserved by Prospective Residents	E Total (A+B+C+D)
Continuing Care Units					
1. Independent Living Units					
2. Assisted Living					
3. Memory Care					
4. Total Assisted Living (Line 2 + Line 3)					
5. Total Continuing Care Units (Line 1 + Line 4)					
Rental Units					
6. Independent Living Rental					
7. Assisted Living Rental					
8. Memory Care Rental					
9. Total Assisted Living Rental (Line 7 + Line 8)					
10. Total Rental Units (Line 6 + Line 9)					
Skilled Nursing Units					
11. Community Beds					
12. Sheltered Beds					
13. Total Skilled Nursing Beds (Line 11 + Line 12)					
Other Continuing Care Contracts					
14. Independent Living					
15. Assisted Living					
16. Memory Care					

Facility Name:

Period Ending:

17. Total Assisted Living (Line 15 + Line 16)					
18. Skilled Nursing					
19. Total Other Continuing Care Contracts (Sum of Lines 14, 17, and 18)					
20. Total of All Units (Sum of Lines 5, 10, 13, and 19)					

RESIDENT COUNT

For each category below, specify the total number of individuals at this Facility as of the end of the reporting period. Continuing care at-home residents should not be included in lines 1 through 4.

Level of Care	A Pursuant to a Continuing Care Contract	B Without a Continuing Care Contract
1. Independent Living		
2. Assisted Living and Memory Care		
3. Skilled Nursing		
4. Total (Sum of Lines 1, 2 and 3)		

5. Please specify how many individuals have contracted with the Provider pursuant to a continuing care at-home contract for this Facility: _____

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS	
1. Cash and Cash Equivalents – Unrestricted	
2. Short-Term Investments – Unrestricted	
3. Accounts Receivable, Net	
4. Entrance Fees Receivable	
5. Other Receivables	
6. Current Portion Assets Limited as to Use:	
a. Excess of Minimum Liquid Reserve Funds	
b. Other Assets Limited as to Use	
7. Prepaid Expenses	
8. Other Current Assets	
9. TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS	
10. Investments – Restricted	
11. Assets Limited as to Use:	
a. Required Minimum Liquid Reserve	
b. Debt Service Reserve – Held by Trustee	
c. Other Funds – Held by Trustee	
d. Other – Not Held by Trustee	
e. Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12. Unrestricted Investments	
13. Property, Plant, and Equipment	
a. Less Accumulated Depreciation	()
14. Other	
15. TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16. TOTAL ASSETS (Line 9 plus Line 15)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES	
1. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2. Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3. Cash Provided (Used) by Operations:	
a. Entrance Fees Received	
b. Entrance Fee Refunds Paid	()
c. Earned Entrance Fees	()
d. Depreciation	
e. Amortization	
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n. Total Operations Adjustments (Sum of Lines A3a through A3m)	
4. Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES	
1. Change in Investments and Assets Limited as to Use	
2. Purchase of Property and Equipment	
3.	
4.	
5. Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES	
1. Repayment of Long Term Debt	()
2. Entrance Fees Refunded	
3.	
4.	
5.	
6. Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS	
1.	Cash and Cash Equivalents – Unrestricted
2.	Short-Term Investments – Unrestricted
3.	Accounts Receivable, Net
4.	Entrance Fees Receivable
5.	Other Receivables
6.	Current Portion Assets Limited as to Use:
a.	Excess of Minimum Liquid Reserve Funds
b.	Other Assets Limited as to Use
7.	Prepaid Expenses
8.	Other Current Assets
9.	TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)
NON-CURRENT ASSETS	
10.	Investments – Restricted
11.	Assets Limited as to Use:
a.	Required Minimum Liquid Reserve
b.	Debt Service Reserve – Held by Trustee
c.	Other Funds – Held by Trustee
d.	Other – Not Held by Trustee
e.	Total Assets Limited as to Use (Sum of Lines 11a through 11d)
12.	Unrestricted Investments
13.	Property, Plant, and Equipment
a.	Less Accumulated Depreciation ()
14.	Other
15.	TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)
16.	TOTAL ASSETS (Line 9 plus Line 15)

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
OTHER INCOME (EXPENSE)		
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES	
2.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)
2.	Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)
3. Cash Provided (Used) by Operations:	
a.	Entrance Fees Received
b.	Entrance Fee Refunds Paid ()
c.	Earned Entrance Fees ()
d.	Depreciation
e.	Amortization
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n.	Total Operations Adjustments (Sum of Lines A3a through A3m)
4.	Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)
B. INVESTING ACTIVITIES	
1.	Change in Investments and Assets Limited as to Use
2.	Purchase of Property and Equipment
3.	
4.	
5.	Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)
C. FINANCING ACTIVITIES	
1.	Repayment of Long Term Debt ()
2.	Entrance Fees Refunded
3.	
4.	
5.	
6.	Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

EXHIBIT A – INTERROGATORIES

For any “Yes” responses, please upload an explanation and any required documentation into the filing. The supporting documentation should be uploaded as a Miscellaneous Document. Please label the documentation appropriately for ease of reference when reviewing the filing.

1. If the Provider is a limited partnership, has the general partner changed since the last filing submission?
 - ☐ Yes
 - ☐ No
2. Has any individual or entity assumed ownership or possession of or control over 10% or more of the Provider, a controlling company of the Provider, or the Provider’s assets, based on the balance sheet from the most recent audited financial report filed with the Office, since the last filing submission?
 - ☐ Yes
 - ☐ No
3. Have there been any other changes in the officers, directors, shareholders of the Provider since the last filing submission?
 - ☐ Yes
 - ☐ No
4. Have there been any changes to managers of or management company for the Facility, including the Executive Director, Facility Administrator, or equivalent position, since the last filing submission?
 - ☐ Yes
 - ☐ No
5. Have there been any changes to the Provider’s organizational structure since the last filing submission?
 - ☐ Yes
 - ☐ No
6. Have there been any changes to the Provider’s organizational documents since the last filing submission? Organizational documents include but are not limited to: articles of incorporation, by-laws, partnership agreement, articles of association, trust agreement, etc.
 - ☐ Yes
 - ☐ No
7. Have any judgments or fines been entered against the Provider since the last filing submission?
 - ☐ Yes
 - ☐ No
8. With respect to any business operations of the Provider, have any bankruptcy, delinquency, receivership, foreclosure or loan default proceedings been initiated since the last filing submission?
 - ☐ Yes
 - ☐ No
9. Is the Provider out of compliance with any terms, conditions, or covenants established in lending agreements for long-term financing?
 - ☐ Yes
 - ☐ No

Facility Name:
Period Ending:

10. Since the last filing submission, have any administrative actions been initiated against any of the following:
- the Provider or any of its officers, directors, or controlling persons;
 - any affiliates of the Provider;
 - the managers or management company of the Facility, including the Executive Director, Facility Administrator, or equivalent position; or
 - any entity providing shelter, nursing care, or personal services pursuant to the Provider's continuing care contracts.
- ☐ Yes
☐ No
11. Since the last filing was submitted, have any of individuals described below been convicted of or pled nolo contendere to a crime, other than a minor traffic violation:
- any officer, director, or controlling person of the Provider; or
 - any managers of the Facility, including the Executive Director, Facility Administrator, or equivalent positions; or
 - any employees or principals of the Facility's management company performing roles similar to those listed above.
- ☐ Yes
☐ No
12. During the reporting period or at any time since the last filing submission, has the Provider failed to pay its obligations as they come due in the normal course of business? For the purposes of this question, "the normal course of business" is defined as the time agreed upon by the involved parties.
- ☐ Yes
☐ No
13. If the answer is yes to item 12, please select all applicable creditor types that the Provider was or is unable to pay timely.
- ☐ Residents or prospective residents (refunds)
 - ☐ Health care providers
 - ☐ Prescription drug vendors
 - ☐ Food vendors
 - ☐ Lenders
 - ☐ Employees
 - ☐ Contract employees or consultants
 - ☐ Construction, maintenance, or similar companies
 - ☐ Insurers
 - ☐ Local, state, or federal government entities (taxes, fees)
 - ☐ Other:
14. Has the Provider closed on any new financing, additional financing, or refinancing since the last filing submission?
- ☐ Yes
☐ No

Facility Name:

Period Ending:

SCHEDULE A – MINIMUM LIQUID RESERVES FOR FACILITIES WITH FINANCING

- Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE B.
 - Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE B and are not required to complete this schedule.
1. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve (“MLR”) Calculation, Form OIR-A3-477, (“MLR Calculation”) filed for the Provider’s current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider’s Annual Report is due, which is 181 days after the end of the Provider’s fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year begins 61 days after the recalculation of the MLR is filed and ends 60 day after the Provider’s annual statement is due, which is 180 days after the last day of the Provider’s fiscal year.
 2. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider’s minimum liquid reserves.
 - a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.
 - b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1b, 1c, 3b, 3c, 5e, or 5f, as applicable.
 - c. If the Provider comingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 6510.033, Florida Statutes, the Provider may allocate the balance(s) between Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable. However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.
 - d. If the Provider has a debt service reserve established pursuant to a trust indenture or mortgage lien on the facility, it may be included in Lines 1d and 1e if the Provider has filed the documents specified in Section 651.035(1)(b), Florida Statutes, with the Office. The sum of Lines 1dB and 1eB cannot exceed the Allowable Amount specified in Column 74, Schedule VII, number 74 of the Minimum Liquid Reserve Calculation,
 3. Funds included in the Provider’s MLR are recorded in Lines 6a and 11a of the Facility’s Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility’s Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
Total Trustee Held Debt Service Reserve Funds:		
d.		
e.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Line 3a + 3b)		
5. Renewal & Replacement Reserve		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum 5a through 5d)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

Facility Name:
Period Ending:

SCHEDULE B – MINIMUM LIQUID RESERVES FOR FACILITIES WITHOUT FINANCING

- Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE A.
 - Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE A and are not required to complete this schedule.
1. Calculating the Debt Service Reserve - Tax Reserve Requirement
 - a. Annual Property Tax Liability as indicated in the most recent tax notice provided pursuant to s. 197.322(3)
 - b. $1.a / 12 =$ Monthly Tax Reserve Deposit Amount
 - c. Date the Property Taxes were paid:
 - d. $(\text{number of months since property taxes were paid}) \times 1.b =$ Line 1A below.
 2. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve ("MLR") Calculation, Form OIR-A3-477, ("MLR Calculation") filed for the Provider's current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider's Annual Report is due, which is 181 days after the end of the Provider's fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year begins 61 days after the recalculation of the MLR is filed and ends 60 day after the Provider's annual statement is due, which is 180 days after the last day of the Provider's fiscal year.
 3. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider's minimum liquid reserves.
 - a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.
 - b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable.
 - c. If the Provider comingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 6510.033, Florida Statutes, the Provider may allocate the balance(s) between Lines However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.
 4. Funds included in the Provider's MLR are recorded in Lines 6a and 11a of the Facility's Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility's Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Line 3a + 3b)		
5. Renewal & Replacement Reserve		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5e)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		



Florida Office of Insurance Regulation

QUARTERLY FINANCIAL REPORT

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

QUARTERLY FINANCIAL REPORT OF

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

FOR PERIOD ENDED

Facility Name:
Period Ending:

GENERAL INFORMATION AND INSTRUCTIONS

The Florida Office of Insurance Regulation (“Office”) issues a Certificate of Authority to the Provider, which is the legal entity that issues contracts for continuing care for a Facility, including residency agreements, reservation agreements, and waitlist agreements. Separate Certificates of Authority are issued for each Facility, which can result in a single Provider holding multiple Certificates of Authority and, therefore, submitting multiple reports for the same period. In addition to operating multiple Facilities, it is not unusual for Providers to engage in business other than providing continuing care in Florida. As a result, the Office requires financial information at the Provider and Facility level to evaluate the financial condition.

Further, many continuing care Providers are part of holding company structures through which they are affiliated with other Florida Providers through common ownership or control. These instructions are intended to clarify reporting requirements so that the Office has a clear understanding of the participants in the Florida market, regardless of organizational structure.

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
2. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
3. Submit this form electronically via the Office’s system at <https://www.florir.com/iportal>.
4. All questions and portions of this form must be completed in order for the filing to be considered complete—do not leave any items blank. For the financial statements, please ensure to enter 0 for numerical values and N/A for text responses, as appropriate, rather than leaving the field blank.
5. If additional explanations, supporting statements, documentation, or schedules are necessary, please upload them to the filing by attaching them as a Miscellaneous Document. Please add a label to the Miscellaneous Document that describes the attachment for ease of reference. Any attachments should be in a readable electronic format (i.e. Word, Excel, PDF, etc.).
6. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.
7. Financial Statements. Provide a Balance Sheet, Statement of Operations, and Statement of Cash Flows (collectively “Financial Statements”) for both the Facility and the Provider. If operating the Facility is the Provider’s only business, we would expect the Financial Statements for the Provider and Facility to be identical. If the Provider has more than one Facility or is engaged in other business in addition to operating the Facility, we would expect the Facility’s Financial Statements to reflect the financial position and operations of the Facility as a sub-unit of the Provider and the Provider’s Financial Statements to reflect the financial position of the Provider and all of its operations.
8. Minimum Liquid Reserves. Section 651.035, Florida Statutes, establishes minimum liquid reserve requirements that must be maintained by a Provider for each Facility. Minimum liquid reserve (“MLR”) funds must be maintained in escrow or on deposit with the Department of Financial Services, Bureau of Collateral Management. MLR funds are recorded in Lines 6a and 11a of the Balance Sheet.

In addition, Providers shall submit a schedule detailing MLR funding and accounts. Providers with financing on the Facility should complete SCHEDULE A and not SCHEDULE B. Providers without financing on the Facility should complete SCHEDULE B and not SCHEDULE A.

9. Escrow Statements. To document compliance with the Minimum Liquid Reserve Requirement, please upload escrow statements as a component of this filing. For the purpose of SCHEDULE A and SCHEDULE B, If a Provider uses a single MLR account for one or more of the Facility’s MLR reserves, the Provider

Facility Name:

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should evenly apportion the funds between the appropriate reserve types for the purpose of completing the MLR schedule.

10. If a Provider owns more than one Facility, or if the Provider is affiliated through common ownership or control with additional Providers owning Facilities in Florida, please include a Provider Group Code on the cover page for the monthly, quarterly, and annual filings.
11. Obligated Groups. A Provider that is a member of an Obligated Group should complete SCHEDULE D and should not complete SCHEDULE C. A Provider that is not a member of an Obligated Group should complete SCHEDULE C and should not complete SCHEDULE D.

Facility Name:
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ATTESTATION

This filing will not be considered complete unless it has attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies the page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20_____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20_____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

Facility Name:
Period Ending:

UNIT ANALYSIS

Please complete the table below regarding the units at the Facility. For the purposes of completing the Unit Analysis, please refer to the descriptions below.

Continuing Care Units: Units, other than Skilled Nursing Units, occupied by or to be occupied by at least one continuing care contract holder. Units that are *Available to Market and Unsold* or *Unavailable to Market* should be reported in this section, rather than the Rental Units section, unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Assisted Living and Memory Care Units: For lines 2, 7 and 15, please report the number of Assisted Living Units that the Provider does not consider to be Memory Care Units as of the reporting date. For lines 3, 8, and 16, please report the number of units that the Provider considers to be Memory Care Units as of the reporting date. If the Provider does not make a distinction between Assisted Living and Memory Care, please report all units as Assisted Living in lines 2, 7, and 15, and enter 0s for lines 3, 8, and 16.

Rental Units: Rental Units are those occupied by individuals who are not continuing care contract holders. *Available to Market and Unsold* and *Unavailable to Market Units* should be reported as Continuing Care Units unless the Provider has discontinued marketing all or a specific portion of the Facility to prospective continuing care contract holders.

Skilled Nursing Units: Community Beds refers to Skilled Nursing Units occupied by or available to individuals who are not continuing care contract holders. Sheltered Beds refers to Skilled Nursing Units occupied by or available only to continuing care contract holders.

Other Continuing Care Contracts: This section refers to continuing care contract holders residing at a location that is not operated by the Provider. Line 14 refers to individuals with continuing care at-home contracts that are not currently residing at the Facility. Lines 15 through 19 refer to continuing care or continuing care at-home contract holders residing at a location that is not operated by the Provider.

	A Occupied or Sold	B Available to Market and Unsold	C Unavailable to Market	D Reserved by Prospective Residents	E Total (A+B+C+D)
Continuing Care Units					
1. Independent Living Units					
2. Assisted Living					
3. Memory Care					
4. Total Assisted Living (Line 2 + Line 3)					
5. Total Continuing Care Units (Line 1 + Line 4)					
Rental Units					
6. Independent Living Rental					
7. Assisted Living Rental					
8. Memory Care Rental					
9. Total Assisted Living Rental (Line 7 + Line 8)					
10. Total Rental Units (Line 6 + Line 9)					
Skilled Nursing Units					
11. Community Beds					
12. Sheltered Beds					
13. Total Skilled Nursing Beds (Line 11 + Line 12)					
Other Continuing Care Contracts					
14. Independent Living					
15. Assisted Living					
16. Memory Care					

Facility Name:

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17. Total Assisted Living (Line 15 + Line 16)					
18. Skilled Nursing					
19. Total Other Continuing Care Contracts (Sum of Lines 14, 17, and 18)					
20. Total of All Units (Sum of Lines 5, 10, 13, and 19)					

RESIDENT COUNT

For each category below, specify the total number of individuals at this Facility as of the end of the reporting period. Continuing care at-home residents should not be included in lines 1 through 4.

Level of Care	A Pursuant to a Continuing Care Contract	B Without a Continuing Care Contract
1. Independent Living		
2. Assisted Living and Memory Care		
3. Skilled Nursing		
4. Total (Sum of Lines 1, 2 and 3)		

5. Please specify how many individuals have contracted with the Provider pursuant to a continuing care at-home contract for this Facility: _____

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS	
1.	Cash and Cash Equivalents – Unrestricted
2.	Short-Term Investments – Unrestricted
3.	Accounts Receivable, Net
4.	Entrance Fees Receivable
5.	Other Receivables
6.	Current Portion Assets Limited as to Use:
a.	Excess of Minimum Liquid Reserve Funds
b.	Other Assets Limited as to Use
7.	Prepaid Expenses
8.	Other Current Assets
9.	TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)
NON-CURRENT ASSETS	
10.	Investments – Restricted
11.	Assets Limited as to Use:
a.	Required Minimum Liquid Reserve
b.	Debt Service Reserve – Held by Trustee
c.	Other Funds – Held by Trustee
d.	Other – Not Held by Trustee
e.	Total Assets Limited as to Use (Sum of Lines 11a through 11d)
12.	Unrestricted Investments
13.	Property, Plant, and Equipment
a.	Less Accumulated Depreciation ()
14.	Other
15.	TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)
16.	TOTAL ASSETS (Line 9 plus Line 15)

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**PROVIDER FINANCIAL STATEMENTS
PROVIDER STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES	
1. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2. Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3. Cash Provided (Used) by Operations:	
a. Entrance Fees Received	
b. Entrance Fee Refunds Paid	()
c. Earned Entrance Fees	()
d. Depreciation	
e. Amortization	
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n. Total Operations Adjustments (Sum of Lines A3a through A3m)	
4. Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES	
1. Change in Investments and Assets Limited as to Use	
2. Purchase of Property and Equipment	
3.	
4.	
5. Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES	
1. Repayment of Long Term Debt	()
2. Entrance Fees Refunded	
3.	
4.	
5.	
6. Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS	
1. Cash and Cash Equivalents – Unrestricted	
2. Short-Term Investments – Unrestricted	
3. Accounts Receivable, Net	
4. Entrance Fees Receivable	
5. Other Receivables	
6. Current Portion Assets Limited as to Use:	
a. Excess of Minimum Liquid Reserve Funds	
b. Other Assets Limited as to Use	
7. Prepaid Expenses	
8. Other Current Assets	
9. TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS	
10. Investments – Restricted	
11. Assets Limited as to Use:	
a. Required Minimum Liquid Reserve	
b. Debt Service Reserve – Held by Trustee	
c. Other Funds – Held by Trustee	
d. Other – Not Held by Trustee	
e. Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12. Unrestricted Investments	
13. Property, Plant, and Equipment	
a. Less Accumulated Depreciation	()
14. Other	
15. TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16. TOTAL ASSETS (Line 9 plus Line 15)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES	
17. Accounts Payable	
18. Accrued Expenses	
19. Accrued Interest	
20. Current Portion of Entrance Fee Refunds Payable	
21. Current Portion of Long-Term Debt:	
a. On Facility	
b. Other	
22. Current Portion of Notes Payable	
23. Other Short Term Liabilities	
24. TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES	
25. Long-Term Debt:	
a. On Facility	
b. Other	
26. Notes Payable	
27. Refundable Entrance Fees	
28. Deferred Revenue from Entrance Fees	
29. Other Long Term Liabilities	
30. TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31. TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY	
32. Beginning Net Assets (Deficit) / Equity	
33. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34. Other Contributions or Adjustments	
35. TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36. TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**FACILITY FINANCIAL STATEMENTS
FACILITY STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES	
2. Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2. Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3. Cash Provided (Used) by Operations:	
a. Entrance Fees Received	
b. Entrance Fee Refunds Paid	()
c. Earned Entrance Fees	()
d. Depreciation	
e. Amortization	
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n. Total Operations Adjustments (Sum of Lines A3a through A3m)	
4. Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES	
1. Change in Investments and Assets Limited as to Use	
2. Purchase of Property and Equipment	
3.	
4.	
5. Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES	
1. Repayment of Long Term Debt	()
2. Entrance Fees Refunded	
3.	
4.	
5.	
6. Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
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EXHIBIT A – INTERROGATORIES

For any “Yes” responses, please upload an explanation and any required documentation into the filing. The supporting documentation should be uploaded as a Miscellaneous Document. Please label the documentation appropriately for ease of reference when reviewing the filing.

1. If the Provider is a limited partnership, has the general partner changed since the last filing submission?
 - ☐ Yes
 - ☐ No
2. Has any individual or entity assumed ownership or possession of or control over 10% or more of the Provider, a controlling company of the Provider, or the Provider’s assets, based on the balance sheet from the most recent audited financial report filed with the Office, since the last filing submission?
 - ☐ Yes
 - ☐ No
3. Have there been any other changes in the officers, directors, shareholders of the Provider since the last filing submission?
 - ☐ Yes
 - ☐ No
4. Have there been any changes to managers of or management company for the Facility, including the Executive Director, Facility Administrator, or equivalent position, since the last filing submission?
 - ☐ Yes
 - ☐ No
5. Have there been any changes to the Provider’s organizational structure since the last filing submission?
 - ☐ Yes
 - ☐ No
6. Have there been any changes to the Provider’s organizational documents since the last filing submission? Organizational documents include but are not limited to: articles of incorporation, by-laws, partnership agreement, articles of association, trust agreement, etc.
 - ☐ Yes
 - ☐ No
7. Have any judgments or fines been entered against the Provider since the last filing submission?
 - ☐ Yes
 - ☐ No
8. With respect to any business operations of the Provider, have any bankruptcy, delinquency, receivership, foreclosure or loan default proceedings been initiated since the last filing submission?
 - ☐ Yes
 - ☐ No
9. Is the Provider out of compliance with any terms, conditions, or covenants established in lending agreements for long-term financing?
 - ☐ Yes
 - ☐ No

Facility Name:
Period Ending:

10. Since the last filing submission, have any administrative actions been initiated against any of the following:
- the Provider or any of its officers, directors, or controlling persons;
 - any affiliates of the Provider;
 - the managers or management company of the Facility, including the Executive Director, Facility Administrator, or equivalent position; or
 - any entity providing shelter, nursing care, or personal services pursuant to the Provider's continuing care contracts.
- ☐ Yes
☐ No
11. Since the last filing was submitted, have any of individuals described below been convicted of or pled nolo contendere to a crime, other than a minor traffic violation:
- any officer, director, or controlling person of the Provider; or
 - any managers of the Facility, including the Executive Director, Facility Administrator, or equivalent positions; or
 - any employees or principals of the Facility's management company performing roles similar to those listed above.
- ☐ Yes
☐ No
12. During the reporting period or at any time since the last filing submission, has the Provider failed to pay its obligations as they come due in the normal course of business? For the purposes of this question, "the normal course of business" is defined as the time agreed upon by the involved parties.
- ☐ Yes
☐ No
13. If the answer is yes to item 12, please select all applicable creditor types that the Provider was or is unable to pay timely.
- ☐ Residents or prospective residents (refunds)
 - ☐ Health care providers
 - ☐ Prescription drug vendors
 - ☐ Food vendors
 - ☐ Lenders
 - ☐ Employees
 - ☐ Contract employees or consultants
 - ☐ Construction, maintenance, or similar companies
 - ☐ Insurers
 - ☐ Local, state, or federal government entities (taxes, fees)
 - ☐ Other:
14. Has the Provider closed on any new financing, additional financing, or refinancing since the last filing submission?
- ☐ Yes
☐ No

Facility Name:
Period Ending:

EXHIBIT B – DETAILED LISTING OF THE ASSETS MAINTAINED IN THE MINIMUM LIQUID RESERVES

Please complete and upload the Exhibit B spreadsheet to provide the detailed listing of the assets maintained in the minimum liquid reserves, as required by Section 651.026, Florida Statutes.

Facility Name:

Period Ending:

SCHEDULE A – MINIMUM LIQUID RESERVES FOR FACILITIES WITH FINANCING

- Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE B.
 - Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE B and are not required to complete this schedule.
1. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve (“MLR”) Calculation, Form OIR-A3-477, (“MLR Calculation”) filed for the Provider’s current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider’s Annual Report is due, which is 181 days after the end of the Provider’s fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year begins 61 days after the recalculation of the MLR is filed and ends 60 day after the Provider’s annual statement is due, which is 180 days after the last day of the Provider’s fiscal year.
 2. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider’s minimum liquid reserves.
 - a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.
 - b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1b, 1c, 3b, 3c, 5e, or 5f, as applicable.
 - c. If the Provider commingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 651.033, Florida Statutes, the Provider may allocate the balance(s) between Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable. However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.
 - d. If the Provider has a debt service reserve established pursuant to a trust indenture or mortgage lien on the facility, it may be included in Lines 1d and 1e if the Provider has filed the documents specified in Section 651.035(1)(b), Florida Statutes, with the Office. The sum of Lines 1dB and 1eB cannot exceed the Allowable Amount specified in Column 74, Schedule VII, number 74 of the Minimum Liquid Reserve Calculation,
 3. Funds included in the Provider’s MLR are recorded in Lines 6a and 11a of the Facility’s Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility’s Balance Sheet.

Facility Name:

Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
Total Trustee Held Debt Service Reserve Funds:		
d.		
e.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Line 3a + Line 3b)		
5. Renewal & Replacement Reserve		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5d.)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

Facility Name:
Period Ending:

SCHEDULE B – MINIMUM LIQUID RESERVES FOR FACILITIES WITHOUT FINANCING

- Providers without a mortgage loan or other long-term financing on the Facility for which this report is filed must complete this schedule and are not required to complete SCHEDULE A.
 - Providers with a mortgage loan or other long-term financing on the Facility for which this report is filed must complete SCHEDULE A and are not required to complete this schedule.
1. Calculating the Debt Service Reserve - Tax Reserve Requirement
 - a. Annual Property Tax Liability as indicated in the most recent tax notice provided pursuant to s. 197.322(3)
 - b. $1.a / 12 =$ Monthly Tax Reserve Deposit Amount
 - c. Date the Property Taxes were paid:
 - d. $(\text{number of months since property taxes were paid}) \times 1.b =$ Line 1A below.
 2. In Row A, enter the Required Reserve Amounts in effect as of the period ended date of this filing. Lines 1A, 3A, 5A, and 7A must agree with the amounts in Lines 58 through 61, Schedule VI(A) of the Minimum Liquid Reserve ("MLR") Calculation, Form OIR-A3-477, ("MLR Calculation") filed for the Provider's current MLR funding year. The MLR funding year is specified in Line 4 of the MLR Calculation and begins 61 days after a Provider's Annual Report is due, which is 181 days after the end of the Provider's fiscal year. However, in event of a change to the aggregate amount of all principal and interest payments due during the fiscal year, the Office may require a recalculation of the MLR. In the event of a recalculation, the funding year begins 61 days after the recalculation of the MLR is filed and ends 60 day after the Provider's annual statement is due, which is 180 days after the last day of the Provider's fiscal year.
 3. In Row B, record the balance as of the period ended date of this filing for the escrow accounts included in the Provider's minimum liquid reserves.
 - a. Funds on deposit the Department of Financial Services Bureau of Collateral Management (DFS) should be entered on Lines 1a, 3a, or 5c, as applicable.
 - b. For escrow accounts established pursuant to Section 651.033, Florida Statutes, enter the name of the financial institution in which the account is established and the last 4 digits of the account number in Lines 1a, 1b, 1c, 3a, 3b, 3c, 5c, 5d, and 5e, as applicable.
 - c. If the Provider comingles debt service, operating, or renewal and replacement reserves on deposit with DFS or in one or more unencumbered escrow accounts established pursuant to Section 6510.033, Florida Statutes, the Provider may allocate the balance(s) between Lines However, in no event may encumbered debt service reserve funds be used to offset shortfalls in the operating or renewal and replacement reserve.
 4. Funds included in the Provider's MLR are recorded in Lines 6a and 11a of the Facility's Balance Sheet. Trustee Held Debt Service Reserve funds in excess of the Allowable Amount should be recorded in Line 11b of the Facility's Balance Sheet.

Facility Name:
Period Ending:

Please provide the following information regarding the Provider's minimum liquid reserves for this Facility and its compliance with Section 651.035, Florida Statutes.

	A Required Reserve Amount	B Account Balance
1. Debt Service Reserve		
a. DFS		
Escrow Accounts:		
b.		
c.		
2. Total Debt Service Reserve (Sum of Lines 1a through 1c)		
3. Operating Reserve		
a. DFS		
Escrow Accounts		
b.		
c.		
4. Total Operating Reserve (Lines 3a + 3b)		
5. Renewal & Replacement Reserve		
a. <i>(Less any approved withdraw for which the Provider is making timely repayments)</i>		
b. Current Renewal & Replacement Requirement		
c. DFS		
Escrow Accounts		
d.		
e.		
6. Total Renewal and Replacement Reserve (Sum of Lines 5a through 5e)		
7. Total Minimum Liquid Reserves (Sum of Lines 2, 4, and 6)		

Facility Name:
Period Ending:

SCHEDULE C – QUARTERLY CALCULATION OF FINANCIAL AND OPERATING RATIOS

Preliminary Questions:

1. Has the Provider reached stabilized occupancy?
 - ☐ Yes
 - ☐ No
2. Has the time projected to achieve stabilized occupancy, as reported in the last feasibility study required by the Office as part of an application filing under s. 651.0215, s. 651.023, s. 651.024, or s. 651.0246, elapsed?
 - ☐ Yes
 - ☐ No
 - a. If yes, on what date was the Provider projected to reach stabilized occupancy? _____

I. Days Cash on Hand

1. Please complete the schedules below. Assets are recorded on the Facility Balance Sheet, and Expenses are recorded on the Facility Statement of Operations. Amounts reported below should match the Financial Statements' lines referenced. Lines 1 through 7 will prepopulate based on the Facility Financial Statements in this filing. If the Provider overwrites any of the prepopulated totals, please submit an explanation of the discrepancy.

Assets	Balance as of the Reporting Date
1. Unrestricted cash (Line 1)	
2. Unrestricted short-term investments (Line 2)	
3. Unrestricted long-term investments (Line 12)	
4. Provider restricted funds (Sum of Lines 10 and 11b through 11d)	
5. Minimum liquid reserve (Line 11a)	
6. Excess of minimum liquid reserve (Line 6a)	
7. Days Cash on Hand Numerator (Sum of 1 through 6)	

2. Please complete the schedule below to calculate a 12-month total for the expenses below. Each of Columns A through D should isolate the amount of each category of expense for a single quarter. The amounts of each line item should reflect the values reported in this Financial Statement and previously submitted financial statements, when adjusted to isolate a single quarter.
 - ☐ Column A should reflect the quarterly total for each expense type, ending with the reporting date.
 - ☐ Column B should reflect the quarterly total for each expense type, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
 - ☐ Column C should reflect the quarterly total for each expense type, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
 - ☐ Column D should reflect the quarterly total for each expense type, ending three quarters prior to the quarter ending on the reporting date.
 - ☐ Column E should reflect the 12-month total for each expense type.

Expenses	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E Expense Totals (Sum of A – D)
8. Operating Expenses (Line 27)					
9. (Depreciation) (Line 25)	()	()	()	()	()
10. (Amortization) (Line 24)	()	()	()	()	()

Facility Name:

Period Ending:

11. (Other Noncash Expenses) (Line 26)	()	()	()	()	()
12. Adjusted Expense Total (Sum of Lines 8 through 11)					
13. Days Cash on Hand Denominator (Line 12 divided by 365)					

3. Days Cash on Hand (Line 7 above divided by Line 13 above) = _____

4. Is a demand note or other parental guarantee included as a short-term or long-term investment for the calculation above?

- ☐ Yes
- ☐ No

a. If yes, please complete the following table. Please provide the Filing ID for the filing number in which the Provider requested to approval to include the demand note or parental guarantee in the days cash on hand calculation. provide the following:

Legal Name of Issuing Entity	Demand Note (select yes or no)	Parental Guarantee (select yes or no)	Amount	Filing ID

b. Please provide the total amount of all demand notes issued by the parent. _____

c. Please upload an attachment to the filing that demonstrates that the total amount of all demand notes issued by the parent do not exceed the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent. The attachment should include a certification by an officer of the parent that the documentation provided is true and correct.

5. Do lenders require the Provider to maintain a minimum number of Days Cash on Hand pursuant to the Provider's financing agreements?

- ☐ Yes
- ☐ No

a. If yes, what is the number of days cash on hand required. _____

b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Days Cash on Hand as of the reporting date. _____

Facility Name:
Period Ending:

II. Occupancy

Occupancy means the total number of occupied independent living units, assisted living/memory care units, and skilled nursing beds in a Facility divided by the total number of units and beds in that Facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

1. The Facility's occupancy averaged over the 12-month period immediately preceding the reporting date is: _____
2. Please select the basis on which occupancy percentage was calculated:
 - ☐ On a daily basis—average of 365
 - ☐ On a weekly basis—average of 52
 - ☐ On a monthly basis—average of 12

Please note that the Provider should retain all data necessary for the Office or an auditor to verify this calculation.

- 3 Do lenders require the Provider to maintain an occupancy ratio pursuant to the Provider's financing agreements?
 - ☐ Yes
 - ☐ No
 - a. If yes, what is the required occupancy ratio? _____
 - b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's occupancy as of the reporting date. _____

Facility Name:
Period Ending:

III. Debt Service Coverage Ratio

1. Does the Provider have debt on the Facility?

- ☐ Yes
- ☐ No

2. Please complete the schedule below to calculate a 12-month total for the expenses below. Each of Columns A through D should isolate the amount of each category of expense for a single quarter. The amounts of each line item should reflect the values reported in this Financial Statement and previously submitted financial statements, when adjusted to isolate a single quarter.

- ☐ Column A should reflect the quarterly total for each expense type, ending with the reporting date.
- ☐ Column B should reflect the quarterly total for each expense type, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
- ☐ Column C should reflect the quarterly total for each expense type, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
- ☐ Column D should reflect the quarterly total for each expense type, ending three quarters prior to the quarter ending on the reporting date.
- ☐ Column E should reflect the 12-month total for each expense type.

Expenses	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E 12 -Month Expense Total (Sum of A-D)
1. Total Expenses (Line 27)					
2. (Interest Expense on Debt Facility) (Line 16)	()	()	()	()	()
3. (Depreciation) (Line 25)	()	()	()	()	()
4. (Amortization) (Line 24)	()	()	()	()	()
5. (Other Noncash Expenses) (Line 26)	()	()	()	()	()
6. Adjusted Expense Total (Sum of E1 through E5)					

3. Please complete the schedule below to calculate a 12-month total for the expenses below. Each of Columns A through D should isolate the amount of each category of revenue for a single quarter. The amounts of each line item should reflect the values reported in this Financial Statement and previously submitted financial statements, when adjusted to isolate a single quarter.

- ☐ Column A should reflect the quarterly total for each revenue type, ending with the reporting date.
- ☐ Column B should reflect the quarterly total for each revenue type, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
- ☐ Column C should reflect the quarterly total for each revenue type, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
- ☐ Column D should reflect the quarterly total for each revenue type, ending three quarters prior to the quarter ending on the reporting date.
- ☐ Column E should reflect the 12-month total for each revenue type.

Facility Name:

Period Ending:

Revenues	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E 12 -Month Expense Total (Sum of A-D)
7. Total Revenues (Line 11)					
8. (Earned Entrance Fees) (Line 5)	()	()	()	()	()
9. (Other Noncash Revenue) (Line 8)	()	()	()	()	()
10. (Nonoperating Gains) (Sum of Lines 6, 7, and 9)	()	()	()	()	()
11. Gross Entrance Fees (Line 3a)					
12. (Refunds Paid) (Line 3b + Line C2)	()	()	()	()	()
13. Adjusted Revenue Total (Sum of E 7 through E12)					

4. Please complete the schedule below to calculate the total debt service due for the 12-month period ending on the reporting date. Each of Columns A through D should isolate the amount of each category of debt service payment due for a single quarter. For the purposes of this calculation, Principal excludes any balloon principal payment amounts, pursuant to Section 651.011(11), Florida Statutes.

- Column A should reflect the quarterly total for each component of debt service, ending with the reporting date.
- Column B should reflect the quarterly total for each component of debt service, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
- Column C should reflect the quarterly total for each component of debt service, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
- Column D should reflect the quarterly total for each component of debt service, ending three quarters prior to the quarter ending on the reporting date.
- Column E should reflect the 12-month total for each component of debt service.

Debt Service	Total for the 12-Month Period Ending on the Reporting Date
14. Principal	
15. Interest	
16. Debt Service Denominator (Sum of Lines 14 and 15)	

5. Debt Service Coverage Ratio ((Line above 13 minus Line 6 above) divided by Line 16 above) = _____

6. Do lenders require the Provider to maintain a debt service coverage ratio pursuant to the Provider's financing agreements?

- Yes
- No

a. If yes, what is the required debt service coverage ratio. _____

b. Pursuant to the calculation specified in the Provider's financing agreements, what is the Provider's Debt Service Coverage Ratio as of the reporting date. _____

Facility Name:
Period Ending:

IV. Additional Information Regarding Financial and Operating Ratios

	A. Lender Requirement	B. Lender Calculation	C. Statutory Requirement	D. Provider's Ratio	E. Meets Threshold <i>(the form will prepopulate with yes or no based on the information provided)</i>
Days Cash on Hand	<i>(Populate with Line 5a, Page 27 or NA)</i>	<i>(Populate with Line 5b, Page 27 or NA)</i>	100	<i>(Populate with Line 3, Page 27)</i>	
Occupancy	<i>(Populate with Line 3a, Page 28 or NA)</i>	<i>(Populate with Line 3b, Page 28 or NA)</i>	80%	<i>(Populate with Line 1, Page 28)</i>	
Debt Service Coverage Ratio	<i>(Populate with Line 6a, Page 30 or NA)</i>	<i>(Populate with Line 6b, Page 30 or NA)</i>	1.20:1	<i>(Populate with Line 4, Page 30)</i>	

1. If Column E. above indicates that the Provider has fallen below two or more of the thresholds set forth in Section 651.011(25), F.S., the Provider is required to submit an explanation of the circumstances and a description of the actions the Provider will take to meet the requirements. This information should be uploaded into the filing as a single document and, pursuant to Section 651.0261(1), F.S., it must be submitted with this quarterly statement.

Facility Name:
Period Ending:

SCHEDULE D – OBLIGATED GROUPS

QUARTERLY CALCULATION OF FINANCIAL AND OPERATING RATIOS AND SUPPORTING FINANCIAL INFORMATION FOR OBLIGATED GROUPS

Use this schedule, not SCHEDULE C, if the Provider has long-term debt on the Facility and the structure of such debt establishes an Obligated Group.

1. Provide the Florida Company Code for all Facilities in the Obligated Group who hold Certificates of Authority issued by the Office below, separated by commas.

2. List all other entities that are members of the Obligated Group.

3. Complete Schedules D(1) and D(2). The Provider must make available all necessary records to verify the information reported in this schedule.

4. The first time this Schedule is completed upload financing documents evidencing the members of Obligated Group, terms and conditions of the financing, any bond covenants or other necessary lender requirements, and other documents as necessary to evidence the financing transaction as an attachment to this filing.

5. If any of the terms and conditions of the financing change after the initial filing, please upload any revised documents, amendments, etc. to as an attachment to the this filing.

6. Has the lender determined that the Obligated Group is out of compliance with any terms, conditions, or covenants of its financing agreement?

- ☐ Yes
- ☐ No

- a. If Yes, please upload a document explaining the issue and the steps the Obligated Group is taking to come into compliance.

Facility Name:
Period Ending:

**SCHEDULE D(1) – OBLIGATED GROUP FINANCIAL STATEMENTS
BALANCE SHEET – ASSETS**

CURRENT ASSETS		
1.	Cash and Cash Equivalents – Unrestricted	
2.	Short-Term Investments – Unrestricted	
3.	Accounts Receivable, Net	
4.	Entrance Fees Receivable	
5.	Other Receivables	
6.	Current Portion Assets Limited as to Use:	
a.	Excess of Minimum Liquid Reserve Funds	
b.	Other Assets Limited as to Use	
7.	Prepaid Expenses	
8.	Other Current Assets	
9.	TOTAL CURRENT ASSETS (Sum of Lines 1 through 8)	
NON-CURRENT ASSETS		
10.	Investments – Restricted	
11.	Assets Limited as to Use:	
a.	Required Minimum Liquid Reserve	
b.	Debt Service Reserve – Held by Trustee	
c.	Other Funds – Held by Trustee	
d.	Other – Not Held by Trustee	
e.	Total Assets Limited as to Use (Sum of Lines 11a through 11d)	
12.	Unrestricted Investments	
13.	Property, Plant, and Equipment	
a.	Less Accumulated Depreciation	()
14.	Other	
15.	TOTAL NON-CURRENT ASSETS (Sum of Lines 10 through 14)	
16.	TOTAL ASSETS (Line 9 plus Line 15)	

Facility Name:
Period Ending:

**OBLIGATED GROUP FINANCIAL STATEMENTS
BALANCE SHEET – LIABILITIES**

CURRENT LIABILITIES		
17.	Accounts Payable	
18.	Accrued Expenses	
19.	Accrued Interest	
20.	Current Portion of Entrance Fee Refunds Payable	
21.	Current Portion of Long-Term Debt:	
a.	On Facility	
b.	Other	
22.	Current Portion of Notes Payable	
23.	Other Short Term Liabilities	
24.	TOTAL CURRENT LIABILITIES (Sum of Lines 17 through 23)	
NON-CURRENT LIABILITIES		
25.	Long-Term Debt:	
a.	On Facility	
b.	Other	
26.	Notes Payable	
27.	Refundable Entrance Fees	
28.	Deferred Revenue from Entrance Fees	
29.	Other Long Term Liabilities	
30.	TOTAL NON-CURRENT LIABILITIES (Sum of Lines 25 through 29)	
31.	TOTAL LIABILITIES (Line 24 plus Line 30)	
NET ASSETS (DEFICIT) / EQUITY		
32.	Beginning Net Assets (Deficit) / Equity	
33.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
34.	Other Contributions or Adjustments	
35.	TOTAL NET ASSETS (DEFICIT) / EQUITY (Line 16 minus Line 31)	
36.	TOTAL LIABILITIES AND NET ASSETS (DEFICIT) / EQUITY (Line 31 plus Line 35)	

Facility Name:
Period Ending:

**OBLIGATED GROUP FINANCIAL STATEMENTS
STATEMENT OF OPERATIONS**

REVENUES	
1.	Resident Service Fees
2.	Healthcare Fees
3.	Rental Revenues
4.	Total Resident Revenues (Sum of Lines 1 through 3)
5.	Amortization of Earned Entrance Fees
6.	Investment Income, Net
7.	Realized Gains (Losses) from Investments
8.	Unrealized Gains (Losses) from Investments
9.	Net Assets Released from Restrictions (This must agree with Line 29)
10.	Other Income
11.	TOTAL REVENUES (Sum of Lines 4 through 10)
EXPENSES	
12.	Resident Services
13.	Dietary Services
14.	Housekeeping, Maintenance and Utilities
15.	Insurance:
a.	On Facility
b.	Other
16.	Interest:
a.	Long-Term Debt on Facility
b.	Other
17.	Leasehold Payments
18.	General and Administrative
19.	Management Fees
20.	Marketing
21.	Healthcare Services
22.	Taxes:
a.	Property
b.	Other
23.	Other Expenses
24.	Amortization
25.	Depreciation

Facility Name:

Period Ending:

26.	Other Non-Cash Operating Expenses (Including interest rate swaps and changes in future service obligation)	
27.	TOTAL EXPENSES (Sum of Lines 12 through 26)	
	OTHER INCOME (EXPENSE)	
28.	Net Realized Gain on Investments and Assets Limited as to Use	
29.	Net Assets Released from Restrictions (This must agree with Line 9)	
30.	Contributions	
31.	CHANGE IN NET ASSETS (DEFICIT) / NET INCOME (LOSS) (Line 11 minus the sum of Lines 26 through 30)	

Facility Name:
Period Ending:

**OBLIGATED GROUP FINANCIAL STATEMENTS
STATEMENT OF CASH FLOWS**

A. OPERATING ACTIVITIES		
1.	Change in Net Assets (Deficit) / Net Income (Loss) (This must agree with Line 31 of the Statement of Operations)	
2.	Adjustments to Reconcile to Change in Net Assets (Deficit) / Net Income (Loss)	
3.	Cash Provided (Used) by Operations:	
a.	Entrance Fees Received	
b.	Entrance Fee Refunds Paid	()
c.	Earned Entrance Fees	()
d.	Depreciation	
e.	Amortization	
f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		
n.	Total Operations Adjustments (Sum of Lines A3a through A3m)	
4.	Net Cash Provided (Used) by Operating Activities (Sum of Lines A1 through A3)	
B. INVESTING ACTIVITIES		
1.	Change in Investments and Assets Limited as to Use	
2.	Purchase of Property and Equipment	
3.		
4.		
5.	Net Cash Provided (Used) by Investing Activities (Sum of Lines B1 through B4)	
C. FINANCING ACTIVITIES		
1.	Repayment of Long Term Debt	()
2.	Entrance Fees Refunded	
3.		
4.		
5.		
6.	Net Cash Provided (Used) by Financing Activities (Sum of Lines C1 through C5)	

Facility Name:

Period Ending:

D.	Increase (Decrease) in Cash (Sum of Lines A4, B5, and C6)	
E.	Cash at Beginning of Period (This must agree with Line 1 of the Balance Sheet and Line F of the Statement of Cash Flows in the prior year's Financial Statements)	
F.	Cash at End of Period (Line D plus Line E) (This must agree with Line 1 of the Balance Sheet)	

Facility Name:
Period Ending:

SCHEDULE D(2) – OBLIGATED GROUP FINANCIAL AND OCCUPANCY RATIOS

If the Provider has long-term debt on the facility and the structure of such debt does not establish an Obligated Group, please complete SCHEDULE C instead of this schedule.

I. Days Cash on Hand

1. Please complete the schedule below. Line items should match the Obligated Group Financial Statement in this filing.

Assets	Balance as of the Reporting Date
1. Unrestricted cash (Line 1)	
2. Unrestricted short-term investments (Line 2)	
3. Unrestricted long-term investments (Line 12)	
4. Provider restricted funds (Sum of Lines 10. and 11b through 11d)	
5. Minimum liquid reserve (Line 11a)	
6. Excess of minimum liquid reserve (Line 6a)	
7. Days Cash on Hand Numerator (Sum of Lines 1 through 6)	

2. Please complete the schedule below to calculate a 12-month total for the expenses below. Each of Columns A through D should isolate the amount of each category of expense for a single quarter. The amounts of each line item should reflect the values reported in this Financial Statement and previously submitted financial statements, when adjusted to isolate a single quarter.
- Column A should reflect the quarterly total for each expense type, ending with the reporting date.
 - Column B should reflect the quarterly total for each expense type, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
 - Column C should reflect the quarterly total for each expense type, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
 - Column D should reflect the quarterly total for each expense type, ending three quarters prior to the quarter ending on the reporting date.
 - Column E should reflect the 12-month total for each expense type.

Expenses	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E Expense Totals (Sum of A – D)
8. Operating Expenses (Line 27)					
9. (Depreciation) (Line 25)	()	()	()	()	()
10. (Amortization) (Line 24)	()	()	()	()	()
11. (Other Noncash Expenses) (Line 26)	()	()	()	()	()
12. Adjusted Expense Total (Sum of Lines 8 through 11)					
13. Days Cash on Hand Denominator (Line 12 divided by 365)					

3. Days Cash on Hand (Line 7 above divided by Line 13 above) = _____

Facility Name:
Period Ending:

4. Is a demand note or other parental guarantee included as a short-term or long-term investment for the calculation above?

- ☐ Yes
- ☐ No

- a. If yes, please complete the following table. Please provide the Filing ID for the filing number in which the Provider requested to approval to include the demand note or parental guarantee in the days cash on hand calculation. provide the following:

Issuing Entity	Demand Note	Parental Guarantee	Amount	Filing ID

- b. Please provide the total amount of all demand notes issued by the parent. _____
- c. Please upload an attachment to the filing that demonstrates that the total amount of all demand notes issued by the parent do not exceed the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent. The attachment should include a certification by an officer of the parent that the documentation provided is true and correct.
5. Do lenders require the Obligated Group to maintain a minimum number of Days Cash on Hand pursuant to the Obligated Group's financing agreements?
- ☐ Yes
 - ☐ No
- a. If yes, what is the number of days cash on hand required. _____
- b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Days Cash on Hand as of the reporting date. _____

Facility Name:
Period Ending:

II. Occupancy

Occupancy means the total number of occupied independent living units, assisted living units, and skilled nursing beds in a facility divided by the total number of units and beds in that facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

1. The facility's occupancy averaged over the 12-month period immediately preceding the reporting date is: _____
2. Please select the basis on which occupancy percentage was calculated:
 - ☐ On a daily basis—average of 365
 - ☐ On a weekly basis—average of 52
 - ☐ On a monthly basis—average of 12

Please note that the Provider should retain all data necessary for the Office or an auditor to verify this calculation.

- 3 Do lenders require the Obligated Group to maintain an occupancy ratio pursuant to the Obligated Group's financing agreements?
 - ☐ Yes
 - ☐ No
 - a. If yes, what is the required occupancy ratio? _____
 - b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Occupancy as of the reporting date. _____

Facility Name:
Period Ending:

III. Debt Service Coverage Ratio

1. Please complete the schedule below to calculate a 12-month total for the expenses below. Each of Columns A through D should isolate the amount of each category of expense for a single quarter. The amounts of each line item should reflect the values reported in the Financial Statements submitted for the Obligated Group for this period and previously submitted financial statements, when adjusted to isolate a single quarter.
 - Column A should reflect the quarterly total for each expense type, ending with the reporting date.
 - Column B should reflect the quarterly total for each expense type, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
 - Column C should reflect the quarterly total for each expense type, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
 - Column D should reflect the quarterly total for each expense type, ending three quarters prior to the quarter ending on the reporting date.
 - Column E should reflect the 12-month total for each expense type.

Expenses	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E Expense Total for the 12-month Period Ending on the Reporting Date (Sum of A-D)
1. Total Expenses (Line 27, Page 35)					
2. (Interest Expense on Debt Facility) (Line 16, Page 34)	()	()	()	()	()
3. (Depreciation) (Line 25, Page 35)	()	()	()	()	()
4. (Amortization) (Line 24, Page 35)	()	()	()	()	()
5. (Other Noncash Expenses) (Line 26, Page 35)	()	()	()	()	()
6. Adjusted Expense Total (Sum of 1E – 5E)					

Facility Name:
Period Ending:

2. Please complete the schedule below to calculate a 12-month total for the expenses below. Each of Columns A through D should isolate the amount of each category of revenue for a single quarter. The amounts of each line item should reflect the values reported in the Financial Statements for the Obligated Group for this period and previously submitted financial statements, when adjusted to isolate a single quarter.
- Column A should reflect the quarterly total for each revenue type, ending with the reporting date.
 - Column B should reflect the quarterly total for each revenue type, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
 - Column C should reflect the quarterly total for each revenue type, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
 - Column D should reflect the quarterly total for each revenue type, ending three quarters prior to the quarter ending on the reporting date.
 - Column E should reflect the 12-month total for each revenue type.

Revenues	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E Revenue Total for the 12- month Period Ending on the Reporting Date (Sum of A-D)
7. Total Revenues (Line 11, Page 34)					
8. (Earned Entrance Fees) (Line 5, Page 34)	()	()	()	()	()
9. (Other Noncash Revenue) (Line 8, Page 34)	()	()	()	()	()
10. (Nonoperating Gains) (Sum of Lines 6, 7, and 9, Page 34)	()	()	()	()	()
11. Gross Entrance Fees (Line 3a, Page 36)					
12. (Refunds Paid) (Line 3b, Page 36)	()	()	()	()	()
13. Adjusted Revenue Total (Sum of 8E through 13E)					

Facility Name:
Period Ending:

3. Please complete the schedule below to calculate the total debt service due for the 12-month period ending on the reporting date. Each of Columns A through D should isolate the amount of each category of debt service payment due for a single quarter. For the purposes of this calculation, Principal excludes any balloon principal payment amounts, pursuant to Section 651.011(11), Florida Statutes.
- Column A should reflect the quarterly total for each component of debt service, ending with the reporting date.
 - Column B should reflect the quarterly total for each component of debt service, ending with the quarter prior to the quarter ending on the reporting date ("Prior Quarter 1")
 - Column C should reflect the quarterly total for each component of debt service, ending two quarters prior to the quarter ending on the reporting date ("Prior Quarter 2")
 - Column D should reflect the quarterly total for each component of debt service, ending three quarters prior to the quarter ending on the reporting date.
 - Column E should reflect the 12-month total for each component of debt service.

Debt Service	A Reporting Quarter	B Prior Quarter 1	C Prior Quarter 2	D Prior Quarter 3	E Debt Service Total for the 12-month Period Ending on the Reporting Date (Sum of A-D)
14. Principal					
15. Interest					
16. Debt Service Denominator (Line 14 + Line 15)					

4. Debt Service Coverage Ratio ((Line 13 minus Line 6) divided by Line 16) = _____
5. Do lenders require the Obligated Group to maintain a debt service coverage ratio pursuant to the Provider's financing agreements?
- Yes
 - No
- a. If yes, what is the required debt service coverage ratio. _____
- b. Pursuant to the calculation specified in the Obligated Group's financing agreements, what is the Obligated Group's Debt Service Coverage Ratio as of the reporting date.

Facility Name:
Period Ending:

IV. Additional Information Regarding Financial and Operating Ratios

	Lender Requirement	Lender Calculation	Statutory Requirement	Provider's Ratio	Meets Threshold <i>(the form will prepopulate with yes or no based on the information provided and statutory requirements)</i>
Days Cash on Hand	<i>(Populate with Line 5a, Page 40 or NA)</i>	<i>(Populate with Line 5b, Page 40 or NA)</i>	100	<i>(Populate with Line 3, Page 39)</i>	
Occupancy	<i>(Populate with Line 3a, Page 41 or NA)</i>	<i>(Populate with Line 3b, Page 41 or NA)</i>	80%	<i>(Populate with Line 1, Page 41)</i>	
Debt Service Coverage Ratio	<i>(Populate with Line 6a, Page 44 or NA)</i>	<i>(Populate with Line 6b, Page 44 or NA)</i>	1.20:1	<i>(Populate with Line 4, Page 44)</i>	

1. If a Provider falls below two or more of the thresholds set forth in s. 651.011(25), FS, at the end of any fiscal quarter, the Provider must submit an explanation of the circumstances and a description of the actions it will take to meet the requirements. If the Provider has fallen below two or more thresholds as noted above, please upload the such an explanation and description.



Florida Office of Insurance Regulation

REQUEST FOR WAIVER OF MINIMUM LIQUID RESERVE REQUIREMENT

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

**REQUEST FOR WAIVER OF MINIMUM LIQUID RESERVE REQUIREMENT
FILED BY**

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

FOR PERIOD FROM

[MM/DD/YYYY] TO [MM/DD/YYYY]

GENERAL INSTRUCTIONS

1. Pursuant to Section 651.035(3), Florida Statutes, a Provider that makes principal and interest payments to a trust that is beneficially held by its residents as described in Section 651.023(7), Florida Statutes, may request a waiver of the escrow requirements for mortgage principal and interest contained in Section 651.035(1), Florida Statutes. To request such a waiver, please complete this form and submit the requested supporting documentation. The Office will approve such waiver if it finds that such waiver is not inconsistent with the security protections intended by Chapter 651, Florida Statutes.
2. Note that a Provider that has more than one Facility holding a Certificate of Authority issued by the Office must complete and submit a separate form with supporting documentation for each Facility for which the Provider is requesting a waiver.
3. Submit this form electronically via the Office's system at <https://www.floir.com/iportal>.
4. For a new Facility commencing operations, this form and all supporting documentation must be submitted as Periodic Filing no later than 30 days before the Provider requests the release of moneys held in escrow pursuant to Section 651.023(6), Florida Statutes. After moneys held in escrow have been released pursuant to Section 651.023(6), Florida Statutes, this form and all supporting documentation must be filed with the Annual Report Filing on or before May 1 of each year, if the Provider's fiscal year end is December 31, or within 120 days of the last day of the fiscal year of the Provider if the Provider has declared a fiscal year other than the calendar year.
5. In completing the first page of this filing, the "From" date refers to either:
 - For a new facility commencing operations, the date the Provider intends to secure release of moneys held in escrow pursuant to Section 651.023(6), Florida Statutes; or
 - The first day of a Provider's fiscal year if the Provider has previously secured release of moneys held in escrow have been released pursuant to Section 651.023(6), Florida Statutes.
6. The Provider may request a waiver for a period of up to one year that runs concurrently with the Provider's MLR funding year. The MLR funding year is the 12-month period beginning 61 days after a Provider's Annual Report Filing and Minimum Liquid Reserve Calculation are due to be filed. For example, for a Provider with a fiscal year ending on December 31, the MLR funding year begins July 1 of the subsequent year.
7. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.

ATTESTATION

This filing will not be considered complete unless it has been attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by the managing general partner.
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies of this page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)

(Title)

(Typed Name)

(Date)

State of _____

County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this

_____ day of _____, 20____, by

_____, who is personally known to me or who has produced

(Name of Affiant)

_____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

(Signature)

(Title)

(Typed Name)

(Date)

State of _____

County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this

_____ day of _____, 20____, by

_____, who is personally known to me or who has produced

(Name of Affiant)

_____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

Form OIR-A3-1068

Rev.: 7/20

Rule 69O-193.053

FILING CONTACT

Name: _____

Position/Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Email: _____

WAIVER REQUEST

1. The Provider is requesting a waiver of the debt service reserve requirements of 651.035(1), Florida Statutes, for the period of from [MM/DD/YYYY] to [MM/DD/YYYY] pursuant to Section 651.035(3), Florida Statutes.

2. a. Has a request for waiver previously been approved for this Facility?

- ☐ Yes
- ☐ No

b. If yes, the please provide the Filing ID number for each filing in which the previously approved requests for waiver were filed. Please separate each Filing ID number with a comma.

3. Please provide the following contact information for the Trustee.

Name: _____

Position/Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Email: _____

4. Provide a copy of the most recent Audited Financial Statements for the Trust.

5. When making an initial Request for Waiver, provide the following documentation.

a. A schedule of all outstanding debts on the facility and equipment.

- b. Escrow statements evidencing that the released escrowed funds are sufficient to retire all of the outstanding debts on the facility and equipment.
 - c. A sworn statement from an officer of the Provider that upon release the escrowed funds will be used to satisfy all outstanding debts on the facility and equipment.
 - d. A copy of the documents granting to the residents a first mortgage on the land, buildings, and equipment that constitute the Facility. Note that such mortgage shall secure the refund of the entrance fee in the amount required by Chapter 651, Florida Statutes. The granting of the mortgage shall be subject to the following:
 - The first mortgage is granted to an independent trust that is beneficially held by the residents. The mortgage may secure payment on bonds issued to the residents or trustee. Such bonds are redeemable after termination of the residency contract in the amount and manner required by Chapter 651, Florida Statutes, for the refund of an entrance fee.
 - Before granting a first mortgage to the residents, all construction must be substantially completed and substantially all equipment must be purchased. No part of the entrance fees may be pledged as security for a construction loan or otherwise used for construction expenses before the completion of construction.
 - If the Provider is leasing the land or buildings used by the Facility, the leasehold interest must be for a term of at least 30 years.
 - e. A copy of the Trust Indenture. The document creating the trust must include a provision that agrees to an annual audit and to furnish to the Office all information the Office may reasonably require.
 - f. Evidence or documentation that the trust is 100% owned by the residents of the Facility.
6. After a Request for Waiver has been approved by the Office, provide the following documentation in subsequent Requests for Waiver.
- a. Any amendments or other changes to the documents granting to the residents a first mortgage on the land, buildings, and equipment that constitute the Facility.
 - b. Any amendments or other changes to the Trust Indenture.
 - c. If no changes have been made, submit sworn statements from the Trustee and an officer of the Provider that no such amendments or changes have been made.



Florida Office of Insurance Regulation

**SALES AND FINANCIAL REPORT
FOR A NON-OPERATIONAL FACILITY**

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

**SALES AND FINANCIAL REPORT
FOR A NON-OPERATIONAL FACILITY
FILED BY**

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

FOR PERIOD ENDED

Facility Name:
Period Ending:

GENERAL INFORMATION AND INSTRUCTIONS

The Florida Office of Insurance Regulation ("Office") issues a Certificate of Authority to the Provider, which is the legal entity that issues contracts for continuing care for a Facility, including residency agreements, reservation agreements, and waitlist agreements. Separate Certificates of Authority are issued for each Facility, which can result in a single Provider holding multiple Certificates of Authority and, therefore, submitting multiple reports for the same period. In addition to operating multiple Facilities, it is not unusual for Providers to engage in business other than providing continuing care in Florida. As a result, the Office requires financial information at the Provider and Facility level to evaluate the financial condition.

Further, many continuing care Providers are part of holding company structures through which they are affiliated with other Florida Providers through common ownership or control. These instructions are intended to clarify reporting requirements so that the Office has a clear understanding of the participants in the Florida market, regardless of organizational structure.

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
2. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
3. Submit this form electronically via the Office's system at <https://www.flor.com/iportal>.
4. All questions and portions of this form must be completed in order for the filing to be considered complete—do not leave any items blank. For the financial statements, please ensure to enter 0 for numerical values and N/A for text responses, as appropriate, rather than leaving the field blank.
5. If additional explanations, supporting statements, documentation, or schedules are necessary, please upload them to the filing by attaching them as a Miscellaneous Document. Please add a label to the Miscellaneous Document that describes the attachment for ease of reference. Any attachments should be in a readable electronic format (i.e. Word, Excel, PDF, etc.).
6. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.

Facility Name:
Period Ending:

ATTESTATION

This filing will not be considered complete unless it has attested to by the Executive Director or Facility Administrator and, depending on the Provider’s business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies the page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

(Signature)

(Title)

(Typed Name)

(Date)

State of _____
County of _____

The foregoing was sworn to and subscribed before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20____, by _____, who is personally
(Name of Affiant)
known to me or who has produced _____ as identification.

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

Facility Name:
Period Ending:

UNIT RESERVATIONS

The line 1 amount field should equal the amount you would receive if all units were sold. The line 3 amount field should equal the full entrance fee amount for each unit sold, not just the deposit amount.

Total Reservations for CCRC Units:		
	Number	Amount
1. Total CCRC units available for sale, beginning of this period:		
2. Plus CCRC units returned to inventory due to:		
a. Cancellation of Reservation		
b. Death		
c. Other		
d. Total		
3. Less CCRC units reserved during this period:	()	()
4. Total CCRC units available for sale, end of this period: (Line 1 + Line 2d - Line 3)		

Facility Name:
Period Ending:

UNIT RESERVATIONS (At-Home)

The line 1 amount field should equal the amount you would receive if all units were sold. The line 3 amount field should equal the full entrance fee amount for each unit sold, not just the deposit amount.

Total CCRC At-Home Contracts:		
	Number	Amount
1. Total continuing care at-home contracts available for sale, beginning of this period:		
2. Plus continuing care at-home contracts returned to inventory due to:		
a. Cancellation of Reservation		
b. Death		
c. Other		
d. Total		
3. Less continuing care at-home contracts reserved during this period:	()	()
4. Total continuing care at-home contracts available for sale, end of this period: (Line 1 + Line 2d - Line 3)		

Facility Name:
Period Ending:

ENTRANCE FEE CASH SUMMARY REPORT

1. Total Entrance Fees Collected this period: (Include all initial entrance fee deposits and installments collected (\$):		
	Number	Amount
2. Beginning Refunds Due		
3. Refunds Incurred this Period		
4. Refunds Paid this Period	()	()
5. Refunds Due End of Period (Please provide an aging breakdown on any balance due)		
Refund Balances at End of Period (Aging)	Number	Amount
6. Less than 30 Days		
7. 30 - 60 Days		
8. 61 - 90 Days		
9. 91 - 120 Days		
10. * Over 120 Days		
11. TOTAL (Must equal Line 5 above)		
* Explanation required for Refunds over 120 days past due (limited to 1000 characters):		

Facility Name:
Period Ending:

ENTRANCE FEE/RESERVATION FEE
RECONCILIATION OF ESCROW STATEMENT

1. Beginning Balance: (Should agree to ending balance for prior period)		
2. Add:		
a. Sales Deposits		
b. Interest Earned		
c. Other (Explain, limited to 100 characters)		
d. Total		
3. Less:		
a. Refunds	()	
b. Interest Withdrawal	()	
c. Escrow Agent Fee	()	
d. Other (Explain, limited to 100 characters)	()	
e. Total		()
4. Ending Balance per Reconciliation		
5. Ending Balance per Escrow Statement (Attach copy of Escrow Statement supporting balance)		
6. Difference (Provide detailed explanation below, limited to 1000 characters)		



Florida Office of Insurance Regulation

REQUEST FOR WITHDRAWAL FROM MINIMUM LIQUID RESERVES

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

**REQUEST FOR WITHDRAWAL FROM MINIMUM LIQUID RESERVES
FILED BY**

(Continuing Care Provider)

FOR

(Continuing Care Facility)

**TO THE
FLORIDA OFFICE OF INSURANCE REGULATION**

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

GENERAL INSTRUCTIONS

1. Provider may request approval from the Florida Office of Insurance Regulation (“Office”) to withdraw funds from its minimum liquid reserves pursuant to Section 651.035, Florida Statutes; subsection (6) applies to withdrawals from the renewal and replacement reserve and subsection (7)(b) applies to all other withdrawals.
2. To request approval to withdrawal minimum liquid reserve funds, please complete this form and submit the requested supporting documentation. Complete Section I to request a withdrawal from the renewal and replacement reserve pursuant to Section 651.035(6), Florida Statutes, or Section II for any other request to make a withdrawal from the minimum liquid reserves pursuant to Section 651.035(7)(b), Florida Statutes.
3. Submit this form and supporting documentation electronically via the Office’s system at <https://www.floir.com/iportal>.
4. The Office will approve requests for withdrawal from the renewal and replacement reserve that comply with Section 651.035(6), Florida Statutes. In reviewing requests for other withdrawals pursuant to Section 651.035(7)(b), Florida Statutes, the Office may disapprove any request to withdraw funds if it determines that the withdrawal is not in the best interest of the residents.
5. Note that pursuant to Section 651.035(7)(a), Florida Statutes, a provider may withdraw funds held in escrow without the approval of the Office if the amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with Section 651.035, Florida Statutes.
6. The Provider’s MLR funding year is the 12-month period beginning 61 days after a Provider’s Annual Report Filing and Minimum Liquid Reserve Calculation are due to be filed. For example, for a Provider with a fiscal year ending on December 31, the MLR funding year begins July 1 of the subsequent year.
7. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.

ATTESTATION

This filing will not be considered complete unless it has been attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by the managing general partner.
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies of this page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

(Signature)

(Title)

(Typed Name)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____ .

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

(Signature)

(Title)

(Typed Name)

(Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization,

this ____ day of _____, 20____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____ .

(Notary Stamp)

(Signature of the Notary and Date Commission Expires)

FILING CONTACT

Name: _____

Position/Title _____

Address: _____

City: _____ State: _____

Zip: _____

Phone: _____

Ext: _____

Email: _____

I. Request for Withdrawal from the Renewal and Replacement Reserve

Each fiscal year, a Provider may withdraw up to 33 percent of the total renewal and replacement reserve available. The reserve available is equal to the market value of the invested reserves at the end of the Provider's prior fiscal year. The withdrawal must be used for capital items or major repairs. Before any funds are eligible for withdrawal, the Provider must obtain written permission from the Office.

1. Calculate the maximum allowable withdrawal amount.

- A. Provide the following information if the Provider has no outstanding withdrawal balance and its renewal and replacement reserve was fully funded as of the end of the Provider's prior fiscal year. If the Provider has an outstanding withdrawal balance, do not complete A., and complete B., instead.

(1) Provide the total renewal and replacement reserve requirement from Schedule III of the Minimum Liquid Reserve Calculation, Form OIR-A3-477, for the Provider's current MLR funding year:

(2) Calculate the maximum withdrawal allowable by multiplying the amount in 1.A(1) above by .33:

(3) Provide the amount of the requested withdrawal, which cannot exceed the amount calculated in 1.A.(2) above: _____

- B. Provide the following information if the Provider has an outstanding withdrawal balance that was not fully repaid as of the Provider's prior fiscal year.

(1) Provide the total renewal and replacement reserve requirement from Schedule III of the Minimum Liquid Reserve Calculation, Form OIR-A3-477, for the Provider's current MLR funding year:

(2) Provide the following information regarding all previous withdrawals from and repayment of the renewal and replacement reserve with an outstanding balance as of the last fiscal year-end.

	(A) Last Withdrawal	(B) Previous Withdrawal 1	(C) Previous Withdrawal 2	(D) Previous Withdrawal 3	(E) Total Balance Outstanding (A+B+C+D)
Withdrawal amount					
Monthly repayment amount					
Date of 1 st repayment					
Date of final scheduled repayment					
Sum of repayments made as of the most recent fiscal year-end					
Balance outstanding as of most recent fiscal year-end					

(3) Calculate the total available balance by subtracting the amount reported in 2.(E) from the amount reported in 2.B.(1): _____

(4) Calculate the maximum withdrawal allowable by multiplying the amount in (3) above by .33: _____

(5) Provide the amount of the requested withdrawal, which cannot exceed the amount calculated in 1.B.(4) above: _____

2. Provide an anticipated payment schedule.

Within 30 days after the withdrawal of funds, the Provider must begin refunding the reserve account in equal monthly payments that allow for a complete funding of the withdrawal within 36 months. If the Provider fails to make a required monthly payment or the payment is late, the provider must notify the office within 5 days after the due date of the payment and file an updated repayment schedule. No additional withdrawals from the renewal and replacement reserve will be allowed until all scheduled payments are current.

A. Calculate the minimum payment amount by dividing the amount of the requested withdrawal from 1.A.(3) or 1.B.(5), as applicable, by 36: _____

B. Proposed monthly repayment amount cannot be less than the amount calculated in 2.A. above. Monthly payments should be equal in amount, pursuant to Section 651.035(6)(b), Florida Statutes: _____

C. Provide the anticipated date of the proposed monthly repayment amount, which cannot be less than the amount calculated in 2.A. above. Provide the anticipated date of the first payment amount which must be within 30 days of the withdrawal, pursuant to Section 651.035(6)(b), Florida Statutes:

D. Provide the anticipated date of last payment, which may be no later than 36 months after the initial payment: _____

3. Upload to this filing a detailed explanation of the intended use of the proceeds of the renewal and replacement reserve withdrawal. The funds withdrawn may only be used for capital items and major repairs.
4. Upload to this filing current escrow statements demonstrating that the provider is in compliance with the minimum liquid reserve funding requirements for the current MLR funding year.
5. Complete the sworn affidavit attached to this form as Exhibit A and upload it to this filing. After completing the affidavit, print, sign, and notarize it. After the affidavit has been physically signed and notarized, upload a PDF copy into the filing as a Miscellaneous Document titled "Affidavit." This component requires physical signatures from the attesting individuals and the notary. Please review to ensure that the name of the Notary Public, Commission Number, Commission Expiration Date, and any required seal or stamp are visible on the form before submitting the filing.
6. Provide a board resolution indicating board approval of the withdrawal and use of funds as described in this filing. The board resolution should be uploaded into the filing as a Miscellaneous Document titled "Board Resolution."

Requests for Other Withdrawals from the Minimum Liquid Reserves

1. Please provide the amount of the requested withdrawal: _____
2. Please indicate which minimum liquid reserve(s) the Provider is requesting to make a withdrawal from.
 - Debt service reserve
 - Operating reserve
 - Renewal and replacement reserve
3. Please provide the name of the escrow agent and the account numbers for the escrow accounts from which the Provider is requesting to withdraw funds or indicate if the funds are on deposit with the Department of Financial Services Bureau of Collateral Management.

4. What is the intended use of the funds for the requested withdrawal?

5. What is the Provider's plan to fund the repayment of the requested minimum liquid reserve withdrawal?

6. Please upload an anticipated repayment schedule to allow for a complete funding of the requested withdrawal. The repayment schedule should be appropriately labeled and uploaded as a Miscellaneous Document into this filing. The payment schedule must include the following:
 - A. The accounts into which the payments will be deposited;
 - B. The number of payments;
 - C. The anticipated dates of all payments; and
 - D. The amount of payments.
7. Please upload documentation evidencing why the withdraw is necessary for the continued operation of the facility. Documentation should be appropriately labeled and uploaded as a Miscellaneous Document into this filing.
8. Complete the sworn affidavit attached to this form as Exhibit B and upload it to this filing. After completing the affidavit, print, sign, and notarize it. After the affidavit has been physically signed and notarized, upload a PDF copy into the filing as a Miscellaneous Document titled "Affidavit." This component requires physical signatures from the attesting individuals and the notary. Please review to ensure that the name of the Notary Public, Commission Number, Commission Expiration Date, and any required seal or stamp are visible on the form before submitting the filing.
9. Provide a board resolution indicating board approval of the withdrawal request and use of funds as described in this filing. The resolution should include an acknowledgment that if the withdrawal is approved by the Office, the Provider will be impaired pursuant to Chapter 651, Florida Statutes. The board resolution should be uploaded into the filing as a Miscellaneous Document titled "Board Resolution."

EXHIBIT A – AFFIDAVIT

Two officers or general partners of the Provider must complete the following.

I, _____, and I, _____, representing _____, a continuing care Provider licensed to transact business in the state of Florida, after being duly sworn, do depose and certify under penalty of perjury that the intended use of funds for this withdrawal from the renewal and replacement reserve is fully disclosed in this filing and this withdrawal request has been duly authorized and approved by the board of directors of the Provider or a similarly authorized controlling body if the Provider is not organized as a corporation.

Officer/Partner 1:

Officer/Partner 2:

(Signature)

(Signature)

(Name)

(Name)

(Title)

(Title)

(Date)

(Date)

State of _____

State of _____

County of _____

County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, me this _____ day of _____, _____, by _____ as _____ for _____.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, _____, by _____ as _____ for _____.

(Signature of Notary)

(Signature of Notary)

(Print, Type, or Stamp Name of Commissioned Notary)

(Print, Type, or Stamp Name of Commissioned Notary)

Personally Known ___ or Produced Identification ___

Personally Known ___ or Produced Identification ___

Type of Identification Produced

Type of Identification Produced

My Commission Expires

My Commission Expires

EXHIBIT B – AFFIDAVIT

Two officers or general partners of the Provider must complete the following.

I, _____, and I, _____, representing _____, a continuing care Provider licensed to transact business in the state of Florida, after being duly sworn, do depose and certify under penalty of perjury that this filing fully discloses the amount, intended use of funds, and reasons why the withdrawal is necessary for the continued operation of the facility and that this withdrawal request has been duly authorized and approved by the board of directors of the Provider or a similarly authorized controlling body if the Provider is not organized as a corporation. We acknowledge that this withdrawal, if approved, will cause the Provider to be impaired pursuant to Chapter 651, Florida Statutes.

Officer/Partner 1:

Officer/Partner 2:

(Signature)

(Signature)

(Name)

(Name)

(Title)

(Title)

(Date)

(Date)

State of _____

State of _____

County of _____

County of _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, _____, by _____ as _____ for _____.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, _____, by _____ as _____ for _____.

(Signature of Notary)

(Signature of Notary)

(Print, Type, or Stamp Name of Commissioned Notary)

(Print, Type, or Stamp Name of Commissioned Notary)

Personally Known ___ or Produced Identification ___

Personally Known ___ or Produced Identification ___

Type of Identification Produced

Type of Identification Produced

My Commission Expires

My Commission Expires



Florida Office of Insurance Regulation

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.
2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@flor.com

- Submissions should be in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to, or contemporaneously with, the submission of each application filing, with the exception of acquisition filings.
6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.
 7. Questions regarding this process may be directed to pcappcoord@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access <https://fl.ibtfingerprint.com/>, select “Schedule a New Appointment” and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access <https://fl.ibtfingerprint.com/>, select “Register for Fingerprint Card Processing Service” and follow the prompts. Select “No Cards” on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@fior.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the “REF” line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail **ONLY** completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.

OIR-C1-938

Rev: 6/20

Rule 69O-136.100 and 69O-193.003



Florida Office of Insurance Regulation

CONFIDENTIAL

Pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to the public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

**Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: Form A UCAA Type: UCAA Type Other: Other

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Applicant Company Name

Address: Applicant Company Address

City: Applicant Company City

State/Province: State/Province

Postal Code: Postal Code

Phone: Phone

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name

2. a. Are you a citizen of the United States?

☐ Yes

☐ No

b. Are you a citizen of any other country?

☐ Yes

☐ No

If yes, what country? If yes, what country?

3. Affiant's occupation or profession: Affiant's occupation or profession

4. Affiant's business address: Affiant's business address

Business telephone: Business telephone

Business email: Business email

5. Education and training:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>College/University (C/U)</u>	<u>C/U City/State</u>	<u>MM/YY-MM/YY</u>	<u>Degree Obtained</u>

<u>Graduate Studies</u>	<u>College/University</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>

<u>Graduate Studies (GS)</u>	<u>GS College/University</u>	<u>GS City/State</u>	<u>MM/YY-MM/YY</u>	<u>GS Degree Obtained</u>

<u>Other Training: Name</u>	<u>City/State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>

<u>Other Training: Name (OT)</u>	<u>OT City/State</u>	<u>MM/YY-MM/YY</u>	<u>OT Degree/Certification Obtained</u>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

6. List of memberships in professional societies and associations:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>
<u>Name of Soc./Assoc.</u>	<u>Contact Name</u>	<u>Address of Soc./Assoc.</u>	<u>Telephone No. of Soc./Assoc.</u>

7. Present or proposed position with the Applicant Company: Present or proposed position with the Applicant Company

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending

Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

9. a. Have you ever been in a position which required a fidelity bond?

☐ Yes ☐ No

If any claims were made on the bond, give details: Give Details

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

☐ Yes ☐ No

If yes, give details: Give Details

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Question 10, Give Details

Organization/Issuer of License: Org/Issuer License

Address: Address

City: City

State/Province: State/Province

Country: Country

Postal Code: Postal Code

License Type: License Type

License #: License #

Date Issued (MM/YY): MM/YY

Date Expired (MM/YY): MM/YY

Reason for Termination: Reason for Termination

Non-Insurance Regulatory Phone Number (if known): Phone Number

Organization/Issuer of License: Org/Issuer License

Address: Address

City: City

State/Province: State/Province

Country: Country

Postal Code: Postal Code

License Type: License Type

License #: License #

Date Issued (MM/YY): MM/YY

Date Expired (MM/YY): MM/YY

Reason for Termination: Reason for Termination

Non-Insurance Regulatory Phone Number (if known): Phone Number

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

☐ Yes ☐ No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

☐ Yes ☐ No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

☐ Yes ☐ No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

☐ Yes ☐ No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

☐ Yes ☐ No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

☐ Yes ☐ No

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

If yes, provide details including dates, locations, dispositions, etc.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

List any entity subject to regulation by an insurance regulatory authority that control directly or indirectly.

If any of the stock is pledged or hypothecated in any way, give details. Give details if stock is pledged or hypothecated.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

☐ Yes ☐ No

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

Provide Details.

If any of the shares of stock are pledged or hypothecated in any way, give details.

If shares are pledged or hypothecated, give details.

14. Have you ever been adjudged a bankrupt?

☐ Yes ☐ No

If yes, provide details: If yes, provide details.

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. Group Code(s).

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

☐ Yes ☐ No

- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

☐ Yes ☐ No

- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

☐ Yes ☐ No

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

If the answer to any of the above is yes, please indicate and give details.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Dated and signed this Day day of Month 20Year at Click or tap here to enter text.. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

 I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification..

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: Form A UCAA Type: UCAA Type Other: Other

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Applicant Company Name

Address: Applicant Company Address

City: Applicant Company City

State/Province: State/Province

Postal Code: Postal Code

Phone: Phone

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name
IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS
COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

☐ Yes ☐ No

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u> <u>Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>
<u>MM/YY – MM/YY.</u>	<u>Name(s) and Specify</u>	<u>Reason.</u>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: XXX-XX-XXXX.

4. Government Identification Number if not a U.S. Citizen:

Government ID Number:

Govt. ID Number

Govt. ID Number

Govt. ID Number

Country of Issuance:

Country of Issuance

Country of Issuance

Country of Issuance

5. Foreign Student ID# (if applicable): Foreign Student ID Number

6. Date of Birth: (MM/DD/YY): MM/DD/YY

State/Province: State/Province

Place of Birth, City: Place of Birth, City

Country: Country

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

7. Name of Affiant's Spouse (if applicable): Name of Affiant's Spouse

8. List your residences for the last ten (10) years starting with your current address, giving:

<u>Beginning/Ending Dates (MM/YY)</u>	<u>Address</u>	<u>City</u>	<u>State/ Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
<u>MM/YY – MM/YY.</u>	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this Day day of Month, 20Year at Click or tap here to enter text.. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

 I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:

Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Company Name. [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to Company's Designated Person, Position or Department, Address and Phone. [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification:
Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with a pending application of Company Name, [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through Name of CRA and Address, [name of CRA, address] ("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to Company's Designated Person, Position or Department, Address and Phone, [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Printed Full Name and Residence Address.
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this Day day of Month, 20Year by By, and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification.

[SEAL]

Notary Public

Printed Notary Name

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

My Commission Expires

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: Applicant Company Name
NAIC No.: NAIC No.

FEIN: FEIN

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL - INDIVIDUAL

I, _____, the undersigned, do not and will not exercise or attempt to exercise any influence or control, either directly or indirectly, over the business operations, affairs, or activities of _____ ("company"), or any entity owned or controlled by the company and licensed by the Florida Office of Insurance Regulation ("Office"), without the advance written consent of the Office.

I understand that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Witnessed By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL - ENTITY

I, _____, the undersigned, representing _____, certify that other than the individuals listed on the attached register, no person in this entity does or will exercise or attempt to exercise any influence or control, either directly or indirectly, over the business operations, affairs, or activities of _____ ("company"), or any entity owned or controlled by the company and licensed by the Florida Office of Insurance Regulation ("Office"), without the advance written consent of the Office.

I understand that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Witnessed By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

OIR-C1-1468

Rev: 7/21

Rules 69O-136.100 and 69O-193.003, F.A.C.



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL AFFIDAVIT – ENTITY

REGISTER

Below is a complete list of individuals associated with _____
who do or will exercise or attempt to exercise influence or control, either directly or
indirectly, over the business operations, affairs, or activities of the company, or any entity
owned or controlled by the company and licensed by the Office. Date: _____

Name (Typed or Printed)

Position

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

*Additional pages in the same format may be attached as needed.

OIR-C1-1468

Rev: 7/21

Rules 69O-136.100 and 69O-193.003, F.A.C.



Florida Office of Insurance Regulation

DISCLAIMER OF CONTROL - INVESTMENT COMPANIES

I, _____, the undersigned, on behalf of _____ (entity disclaiming control) represent that said entity holds the shares of _____ ("company"), solely for investment purposes, and does not and will not exercise or attempt to exercise any influence or control, either directly or indirectly, over the business operations, affairs, or activities of the company, or any other entity owned or controlled by the company and licensed by the Florida Office of Insurance Regulation ("Office"), without the advance written consent of the Office. I further represent that _____ (entity disclaiming control) does not have, and will not seek, influence or representation on the Board of Directors of the company, or equivalent organizational body.

I understand that pursuant to Section 837.06, Florida Statutes, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Witnessed By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____



Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

OIR-C1-2221

Rev: 6/20

Rule 69O-136.100 and 69O-193.003

**CHAPTER 69P-1
WINDSTORM COVERAGE**

69P-1.001	Plan of Operation and Articles of Agreement Adopted
69P-1.002	Assessment Base Determination
69P-1.011	Purpose
69P-1.012	Definitions
69P-1.013	Time for Filing; Content
69P-1.014	Test for Deferment
69P-1.015	Conditions to Deferred Assessment
69P-1.016	Restrictions
69P-1.017	Effect on Deferred Assessment
69P-1.018	Payments on Surplus Note
69P-1.019	Terms of Surplus Note

69P-1.001 Plan of Operation and Articles of Agreement Adopted.

Rulemaking Authority 624.308(1), 627.351(2) FS. Law Implemented 624.307(1), 627.351(2) FS. History—New 6-29-83, Formerly 4-49.01, Amended 9-7-88, 10-18-90, Formerly 4-49.001, Amended 11-20-95, 12-5-96, 11-19-97, 1-8-01, Formerly 4J-1.001, Repealed.

69P-1.002 Assessment Base Determination.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 627.351(2)(b) FS. History—New 11-20-95, Formerly 4J-1.002, Repealed.

69P-1.011 Purpose.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.01, 4-50.001, 4J-1.011, Repealed.

69P-1.012 Definitions.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.02, 4-50.002, 4J-1.012, Repealed.

69P-1.013 Time for Filing; Content.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.03, 4-50.003, 4J-1.013, Repealed.

69P-1.014 Test for Deferment.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.04, 4-50.004, 4J-1.014, Repealed.

69P-1.015 Conditions to Deferred Assessment.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.05, 4-50.005, 4J-1.015, Repealed.

69P-1.016 Restrictions.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.06, 4-50.006, 4J-1.016, Repealed.

69P-1.017 Effect on Deferred Assessment.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.07, 4-50.007, 4J-1.017, Repealed.

69P-1.018 Payments on Surplus Note.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.08, 4-50.008, 4J-1.018, Repealed.

69P-1.019 Terms of Surplus Note.

Rulemaking Authority 627.351(4) FS. Law Implemented 627.351(4)(d) FS. History—New 7-17-80, Formerly 4-50.09, 4-50.009, 4J-1.019, Repealed.