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

**March 14, 2017**

**MEMBERS**
Governor Rick Scott
Attorney General Pam Bondi
Chief Financial Officer Jeff Atwater
Commissioner Adam Putnam

**Contact:** **Caitlin Murray**
**(850-413-5005)**

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

| ITEM | SUBJECT | RECOMMENDATION |
|---|---|---|

1. Minutes of the Financial Services Commission for December 6, 2016.

   http://www.myflorida.com/myflorida/cabinet/agenda16/1206/transcript.pdf

   **(ATTACHMENT 1)** **FOR APPROVAL**

2. Request for Approval for Final Adoption of Repeal of Rules 69P-5.002-69P-5.012; Surplus Lines Rules (7 Rules)

   These rules should be repealed due to changes in the governing statutes that revised processes now under the supervision of the Florida Surplus Lines Service Office.

   **(ATTACHMENT 2)** **APPROVAL FOR FINAL ADOPTION**

3. Request for Approval for Publication to Repeal Rule 69O-128.025; Confidentiality of Personal Financial and Health Information

   Section 624.23, F. S. defines "personal financial and health information" The rule should be repealed due to conflict with statutory definition.

   **(ATTACHMENT 3)** **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of 69O-137.001 and 69O-138.001

   Section 624.424, Florida Statutes, requires insurers to file quarterly and annual financial reports with the Office of Insurance Regulation and allows the Office to enact rules setting the standards for those reports. The rule is being amended to adopt the 2017 NAIC Quarterly Statement Manuals, the 2016 NAIC Annual Statement Instructions Manuals, the 2016 and 2017 NAIC Accounting Practices and Procedures Manuals and 2017 NAIC User's Guide. The current rule adopted the 2016 NAIC Quarterly Statement Manuals, the 2015 NAIC Annual Statement Instructions Manuals, and the 2015 and 2016 NAIC Accounting Practices and Procedures Manuals.

   Section 624.316, Florida Statutes, requires the Office to examine insurer's financial condition using generally accepted accounting procedures. This statute also allows the Office to adopt the NAIC Financial Condition Examiners Handbook to facilitate these exams. The rule is being amended to adopt the 2016 and 2017 NAIC Financial Condition Examiners Handbooks. The current rule adopted the 2016 and 2015 versions of these handbooks.

**(ATTACHMENT 4)** **APPROVAL FOR PUBLICATION**

5. Request for Approval for Publication of Rules 69O-149.039, 69O-149.040, 69O-149.043, 69O-154.114, 69O-154.305, 69O-154.410, 69O-154.512, 69O-191.051, 69O-191.054, 69O-191.075, 69O-191.091, 69O-191.095, 69O-191.107, 69O-192.058, 69O-194.030,69O-202.008, 69O-202.012, 69O-202.015, 69O-203.042, 69O-203.045, 69O-203.100, 69O-203.210, 69O-157.111, 69O-167.002, 69O-137.002, 69O-137.003, 69O-137.011, 69O-138.005, 69O-138.021, 69O-138.041, 69O-138.043, 69O-141.003, 69O-143.013, 69O-143.030, 69O-143.032, 69O-143.035, 69O-143.042, 69O-143.046, 69O-143.047, 69O-144.007, 69O-167.012, 69O-170.030, 69O-187.006, 69O-187.007, 69O-187.008, 69O-187.009, 69O-188.022, 69O-188.023, 69O-188.024, 69O-196.005, 69O-196.007, 69O-196.009, 69O-196.015, 69O-196.021, 69O-196.025, 69O-196.035, 69O-198.010, 69O-198.012, 69O-198.015, 69O-199.008, 69O-199.010, 69O-199.012, 69O-199.015,69O-200.015, 69O-201.010, 69O-201.012, 69O-207.001, 69O-137.008, 69O-167.011, 69O-170.007, 69O-175.021

   These rule amendments update rules that have obsolete provisions due to the Office's use of electronic filing and posting of forms on the OIR website. Some of the rules also update various forms that are currently in use.

**(ATTACHMENT 5)** **APPROVAL FOR PUBLICATION**

6. Request for Approval for Publication of Repeal of Rules 69O-167.015, 69O-171.004, 69O-176.022, 69O-185.007, 69O-189.007

   These rules were identified for repeal due to repeal of the statutory authority or determined to be obsolete or unnecessary.

**(ATTACHMENT 6)** **APPROVAL FOR PUBLICATION**

7. Office of Insurance Regulation 2nd Quarter Report FY 2016-17

**(ATTACHMENT 7)** **FOR APPROVAL**

**OFFICE OF INSURANCE REGULATION**

GOVERNOR SCOTT: Next I'd like to recognize David Altmaier with the Office of Insurance Regulation.

Good morning, David.

MR. ALTMAIER: Good morning, Governor. Good morning, Cabinet members. It's always a pleasure to be here this morning.

We've got four items for your consideration. The first one is the approval of the Financial Service Commission minutes from September 20th, which are Attachment 1 in your materials, and I respectfully request your approval of those minutes.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

MR. ALTMAIER: Thank you.

Item Number 2 is the approval for publication of repeal for Rule 69P-5.001 through .012. These are the rules that address the collection of taxes for surplus lines insurers, as well as surplus lines agents. And this is a function that is now overseen by the Florida Surplus Lines Service Office, and so these rules are obsolete and should be repealed.

So we respectfully request your approval for publication of those repeals.

GOVERNOR SCOTT: Is there a motion on the item?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

The third item on our agenda is approval for final adoption of amendments to Rule 69O-161.001, .009, .010, and .011. These are amendments that relate to the adoption of a standardized prior authorization form that is used by health insurance

companies, as well as medical providers, in the event that there is not an electronic option.

These rules have gone through our normal rulemaking process, so they've been workshopped; we've conducted a hearing; and the rules before you now reflect that process.

So we respectfully request your final adoption of those rules.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So moved.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

And then the fourth and final item for our agenda today is a review of our first quarter fiscal year '16/'17. As we typically do, we put together a very brief PowerPoint presentation. I'm actually going to just run through it very quickly in the interest of time.

We've had a busy quarter on most of our lines

of business, as you have undoubtedly read all about. What I want to specifically focus on this morning on the P & C side is the response that our industry has had to Hurricane Hermine and Hurricane Matthew.

There are some numbers on the slide in front of you there. The numbers on the left are Hurricane Hermine. That's, obviously, the first storm that came on September the 1st. We're looking at just over 18,000 claims related to Hurricane Hermine. Estimated losses from that storm are $95 million.

We are continuing to collect information from insurance companies with respect to how the claims adjusting process with respect to Hurricane Hermine is going. At this point in time, we have not seen any indication that we would have an insurance company who is unable to meet their financial obligations with respect to Hermine claims.

We have also not seen any trends, CFO Atwater. We're working very closely with your Consumer Services Division. We have not seen any trends from that business unit that would suggest that there are market conduct activities that would warrant additional action on our front. So we're

very encouraged at this point by the response there.

Hurricane Matthew is a similar situation. When we prepared this slide, the most recent information we had was as of October the 28th, and so those numbers on the screen are from October 28th. We have updated information as of yesterday, and so I'll provide those numbers to you now.

Updated Matthew claim information, approximately 112,000 statewide claims filed for Hurricane Matthew; estimated insured losses from Matthew are 729 million. And, again, similar with Hermine, we expect those numbers to fluctuate a bit as the claims adjusting process continues.

Also noteworthy, a very large storm, but we don't see any signs at this point, and we don't expect to see any signs that there's an insurance company operating in these regions that would have trouble meeting their financial obligations with respect to these claims.

We're also very closely monitoring consumer service activity and the call volume to see if there's any market conduct activity that could potentially warrant additional action on our part.

At this point we have not seen any such activity. So we remain encouraged by the response of our industry to both of these storms, and we will continue to diligently monitor how that effort goes going forward.

So this has been our primary focus on the property and casualty front. I do want to just highlight for those that are interested, we do have some interactive spreadsheets on our website for those folks that are interested in getting more detailed information about these claims. We have it split out by line of business, and also by region of the state. So we are happy to assist anyone who is looking to view the state in a more granular fashion.

On the life and health side, we've had a busy front there as well. Some of the things that we've been focused on primarily are long-term care insurance. The last time that I was here, I told you about several significant rate increases that we've seen on the long-term care front. We are on the verge of finalizing those rate filings. We think that we have crafted a pretty good solution that would help protect consumers from significant rate increases in the short term, as well as

provide to them some comfort that they might see some rate stability going forward as well.

So I'm encouraged about that. We are still in negotiation with many of the companies that have filed those, and will continue those discussions with them and announce those just as soon as possible.

Clearly one topic on the radar on the life and health front is the Affordable Care Act, especially now as a result of the elections at the beginning of November. We have discussed this information on this screen with you previously. This is information related to the filings that we received for the claim year 2017 (sic). And as you recall, it's an average increase of foreign exchange products of 19.2% -- excuse me, 19.1%.

We will, obviously, continue to stay engaged in this discussion as we move forward and determine the best approach for this particular segment of the market place in light of the results of the election in November.

Finally, the last thing that I want to highlight from the first quarter, we did conduct our OIR industry conference at the end of October. Several members of your staff participated, and we

appreciate that very much. This is an excellent opportunity for our office to engage with our various stakeholders throughout the industry.

This started several years ago as what we call the filing conference. As you know, many of the filings that our actuaries review and our form specialists review are very complex in nature. So we began a process where we met with industry officials that make those filings with us so that we could talk about ways that we could streamline that process so that we could do what we need to do, and that they could have -- they could recognize some efficiencies in their speed to market process.

This has expanded significantly since its original iteration. We now include legislative updates, financial analysis review, and things of that nature. It's a great opportunity for us to engage with the industry that relies upon us to get their products to the market. They rely upon us to review their financial condition.

We had over 230 industry professionals join us in Tallahassee at the end of October, which is one of our highest numbers yet. I was flattered.

We had a young lady from Cleveland who came

all the way down to Tallahassee the eve of Game 1 of the World Series, and so I was happy that her priorities were in the right place.

We had several folks come from California to join us here in Tallahassee, so it was a great opportunity for us to discuss some of the hot-topic issues that our industry deals with.

And finally, here is our performance measure detail. The bottom line is we achieved a 4.71 for the first quarter, which we're pleased with. You recall the last time that we were here, I had a conversation with you about revising some of these performance standards to more accurately reflect the work that we do at the office, and that is a process that's underway.

I want to highlight three specifically. You'll notice Performance Measures Number 6, 7, and 8 are related to our financial examination process; and if you look to the right, you can see that the result of those are asterisks. That's because at this point in time, we have not completed an examination that would be applicable for the first quarter. That is due to the timing of financial examination.

We go through a planning process with these

examinations, and then we put a team actually in place at the company to conduct the examination. Once their work is finished, we write the report, it's circulated within the Office, and it's shared with the company, and they have an opportunity to respond to the report before it is published.

And so it's a time-consuming process that's not -- the first quarter is typically going to have zeros there. So we have looked at those, and we have decided that we could rework probably Performance Standards Number 7 and 8 to more accurately gauge that process as it takes place; to put in benchmarks that will both challenge the Office of Insurance Regulation, as well as recognize some efficiencies in that examination process.

And so I anticipate that my staff will be working with your staffs on the wording of those updated performance measures and bring them back to you for your consideration.

We also have done very well on the first two performance measures, and so we're going to look to make sure that those performance measures accurately -- well, are challenging enough that if we can recognize some efficiencies there and

improve upon those areas, we certainly will give some consideration to doing that.

But overall, we have a very quality team at the Office. I'm very proud of the work that they put into these performance measures.

And that concludes my remarks on those.

And so I will stop now, and if there are no questions, I would respectfully submit these for your consideration.

GOVERNOR SCOTT: Is there a motion to accept the report?

COMMISSIONER PUTNAM: So move.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

MR. ALTMAIER: Happy Holidays to each of you, and have a great day.

GOVERNOR SCOTT: Thanks, David.

COMMISSIONER PUTNAM: Governor.

GOVERNOR SCOTT: Oh, yes. David, hold on just a second.

COMMISSIONER PUTNAM: I was pleased to hear

that the strength of the companies that were impacted by the two storms this summer was such that it didn't give you any concern.

Without getting into, you know, how the claims break out by company, were you able to get a good glimpse into the newer companies that have come forward, the takeout companies and others who are recent entrants into the Florida market to get a sense of how well they endured these two storms, and be able to then project forward that they're moving in the right direction with respect to their ability to pay claims?

COMMISSIONER ALTMAIER: Yes, we were able to get a glimpse into how our newer companies responded to these events, and I was -- I was personally very encouraged by their response.

Just by way of a small amount of background, this is a process that we undertake on an annual basis where we're reviewing the financial condition of all of our companies, especially our newer ones, to make sure that they have the financial capacity and the reinsurance programs to perform in the event of a hurricane.

When these new companies were licensed, we also did a thorough review of their management

teams. And most of the management teams at the new companies, while the companies themselves are new, the management teams are very experienced with catastrophes and hurricanes; albeit, it's been a while since they've had to deal with one.

So we had those things going for us to begin with. I had a number of conversations with a great many CEOs in the days ahead of each storm to check in on preparations. And I think the mindset of most of these CEOs was they were in sort of a race mentality: We know that there's a storm coming, we have the resources to address it, and we are anxious to put those resources into the field and demonstrate to our consumers that we have the resources to be there when they need us the most.

So we have been able to look at the actual hard data to make sure that those claims are backed up and that review process that we do is sound, and we've been encouraged by the results at this point. We'll continue to remain diligent as the process goes through.

We still have a number of open claims that are out there, so there's still a ways to go with respect to resolving those; but the actual numbers, we should start to see some stability in those

numbers at this point in time, and they're encouraging.

COMMISSIONER PUTNAM: How long would it take to run a model on Matthew 25 miles to the west?

COMMISSIONER ALTMAIER: Not long at all, I would imagine. We can contact the Florida National University. They do the public model.

The calls that I had in the days ahead of the storm, CEOs were actually doing that. It's one of the ways that they plan out where to deploy their resources. So the capabilities for looking at the different trajectories that a storm may take are there, and we do have the technology to do that. We could also look at potentially what might have happened if the storm had been, as you said, 25 miles further west.

We know companies were looking at that information ahead of the storm. They were estimating what their losses might be as if that scenario had played out, as many of us expected might happen. The $729 million number that I read to you a little while ago would have had a couple of extra digits on the end of it if that had happened.

COMMISSIONER PUTNAM: A couple extra commas.

COMMISSIONER ALTMAIER: Yes, sir. And the CEOs, obviously, were gearing up for that event to take place. And in the conversations that I had, people were telling me that they would still, in those events, be able to respond to their consumers' needs and be there to pay their claims. And so while it would have been a much bigger loss, there would have been many more displaced people, and a much more stressful scenario. The CEOs that I spoke with and the review that we've conducted over the past several months ahead of storm season would indicate that they would have been prepared for those losses had they arrived.

COMMISSIONER PUTNAM: Thank you.

MR. ALTMAIER: Thank you.

GOVERNOR SCOTT: Anybody else?

(NO RESPONSE).

GOVERNOR SCOTT: Thanks, David.

COMMISSIONER ALTMAIER: Thank you.

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# M E M O R A N D U M

**DATE:** March 2, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy
Stephen Fredrickson

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Final Approval to Adopt Repeal of
Rule 69P-5.002,.003,.004,.005,.006,.008,.012
Assignment # 182316-15

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on February 22, 2017.

The notice of proposed rules was published on January 6, 2017 in Volume 43, No. 04, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

The rules are now obsolete and should be repealed.

Sections 624.308, 626.916(2), 626.918(2)(d)4, 624.307(1), 626.621(7), 626.914, 626.915, 626.916, 626.924, 626.930, 626.913(2), 626.929(1),626.938, 627.944(3), 627.949(1), 626.918627.736(1), F.S., provide rulemaking authority and laws implemented for these rules.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

Rachic' Glover is the attorney handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

# CHAPTER 69P-5

# UNAUTHORIZED INSURERS AND SURPLUS LINES


69P-5.002 Private Passenger Automobile Physical Damage Insurance

69P-5.003 Statement of Diligent Effort

69P-5.004 Quarterly Report Required

69P-5.005 Report and Tax of Independently Procured Coverages

69P-5.006 Surplus Lines Insurers: Quarterly and Annual Reporting Requirements

69P-5.008 Surplus Lines Surplus Requirement Election Form

69P-5.012 Prohibitions


## 69P-5.002 Private Passenger Automobile Physical Damage Insurance.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 626.914(4), 626.916, 626.924, 626.930 FS. History–New 3-10-92, Formerly 4-11.003, 4J-5.002, Repealed _____.*

## 69P-5.003 Statement of Diligent Effort.

*Rulemaking ~~Specific~~ Authority 624.308, 626.916(2) FS. Law Implemented 624.307(1), 626.913(2), 626.916(1)(a), 626.930(1) FS. History–New 10-1-91, Formerly 4-11.005, Amended 8-28-94, Formerly 4J-5.003, Repealed _____.*

## 69P-5.004 Quarterly Report Required.

*Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 626.914(4), 626.916(1), 626.929(1), 626.931 FS. History–New 5-15-90, Amended 4-1-91, Formerly 4-11.006, 4J-5.004, Repealed _____.*

**69P-5.005 Report and Tax of Independently Procured Coverages.**

*Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 626.938, 627.944(3), 627.949(1) FS. History–New 5-15-90, Formerly 4-11.007, 4J-5.005, Repealed _____.*

**69P-5.006 Surplus Lines Insurers: Quarterly and Annual Reporting Requirements.**

*Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 626.916, 626.931 FS. History–New 6-12-94, Formerly 4J-5.006, Repealed _____.*

**69P-5.008 Surplus Lines Surplus Requirement Election Form.**

*Rulemaking ~~Specific~~ Authority 626.918(2)(d)4. FS. Law Implemented 626.918 FS. History–New 4-26-98, Formerly 4J-5.008, Repealed _____.*

***69P-5.012 Prohibitions.***

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 626.621(7), 626.914, 626.915, 626.916, 627.736(1) FS. History–New 7-6-94, Formerly 4-176.012, 4J-5.012, Repealed _____.*

69P-5.002 thru .012
Rulemaking Authority

624.308 Rules.—

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

626.916 Eligibility for export.—

(1) No insurance coverage shall be eligible for export unless it meets all of the following conditions:

(a) The full amount of insurance required must not be procurable, after a diligent effort has been made by the producing agent to do so, from among the insurers authorized to transact and actually writing that kind and class of insurance in this state, and the amount of insurance exported shall be only the excess over the amount so procurable from authorized insurers. Surplus lines agents must verify that a diligent effort has been made by requiring a properly documented statement of diligent effort from the retail or producing agent. However, to be in compliance with the diligent effort requirement, the surplus lines agent's reliance must be reasonable under the particular circumstances surrounding the export of that particular risk. Reasonableness shall be assessed by taking into account factors which include, but are not limited to, a regularly conducted program of verification of the information provided by the retail or producing agent. Declinations must be documented on a risk-by-risk basis. If it is not possible to obtain the full amount of insurance required by layering the risk, it is permissible to export the full amount.

(b) The premium rate at which the coverage is exported shall not be lower than that rate applicable, if any, in actual and current use by a majority of the authorized insurers for the same coverage on a similar risk.

(c) The policy or contract form under which the insurance is exported shall not be more favorable to the insured as to the coverage or rate than under similar contracts on file and in actual current use in this state by the majority of authorized insurers actually writing similar coverages on similar risks; except that a coverage may be exported under a unique form of policy designed for use with respect to a particular subject of insurance if a copy of such form is filed with the office by the surplus lines agent desiring to use the same and is subject to the disapproval of the office within 10 days of filing such form exclusive of Saturdays, Sundays, and legal holidays if it finds that the use of such special form is not reasonably necessary for the principal purposes of the coverage or that its use would be contrary to the purposes of this Surplus Lines Law with respect to the reasonable protection of authorized insurers from unwarranted competition by unauthorized insurers.

(d) Except as to extended coverage in connection with fire insurance policies and except as to windstorm insurance, the policy or contract under which the insurance is exported shall not provide for deductible amounts, in determining the existence or extent of the insurer's liability, other than those available under similar policies or contracts in actual and current use by one or more authorized insurers.

(e) For personal residential property risks, the retail or producing agent must advise the insured in writing that coverage may be available and may be less expensive from Citizens Property Insurance Corporation. The notice must include other information that states that assessments by Citizens Property Insurance Corporation are higher and the coverage provided by Citizens Property Insurance Corporation may be less than the property's existing coverage. If the notice is signed by the insured, it is presumed that the insured has been informed and knows that policies from Citizens Property Insurance Corporation may be less expensive, may provide less coverage, and will be accompanied by higher assessments.

(2) The commission may by rule declare eligible for export generally, and notwithstanding the provisions of paragraphs (a), (b), (c), and (d) of subsection (1), any class or classes of insurance coverage or risk for which it finds, after a hearing, that there is no reasonable or adequate market among authorized insurers. Any such rules shall continue in effect during the existence of the conditions upon which predicated, but subject to termination by the commission.

(3)(a) Subsection (1) does not apply to wet marine and transportation or aviation risks which are subject to s. 626.917.

(b) Paragraphs (1)(a)-(d) do not apply to classes of insurance which are subject to s. 627.062(3)(d)1. These classes may be exportable under the following conditions:

1. The insurance must be placed only by or through a surplus lines agent licensed in this state;

2. The insurer must be made eligible under s. 626.918; and

3. The insured must sign a disclosure that substantially provides the following: "You are agreeing to place coverage in the surplus lines market. Superior coverage may be available in the admitted market and at a lesser cost. Persons insured by surplus lines carriers are not protected under the Florida Insurance Guaranty Act with respect to any right of recovery for the obligation of an insolvent unlicensed insurer." If the notice is signed by the insured, the insured is presumed to have been informed and to know that other coverage may be available, and, with respect to the diligent-effort requirement under subsection (1), there is no liability on the part of, and no cause of action arises against, the retail agent presenting the form.

(4) A reasonable per-policy fee, not to exceed $35, may be charged by the filing surplus lines agent for each policy certified for export.

626.918 Eligible surplus lines insurers.—

(1) A surplus lines agent may not place any coverage with any unauthorized insurer which is not then an eligible surplus lines insurer, except as permitted under subsections (5) and (6).

(2) An unauthorized insurer may not be or become an eligible surplus lines insurer unless made eligible by the office in accordance with the following conditions:

(a) Eligibility of the insurer must be requested in writing by the Florida Surplus Lines Service Office.

(b) The insurer must be currently an authorized insurer in the state or country of its domicile as to the kind or kinds of insurance proposed to be so placed and must have been such an insurer for not less than the 3 years next preceding or must be the wholly owned subsidiary of such authorized insurer or must be the wholly owned subsidiary of an already eligible surplus lines insurer as to the kind or kinds of insurance proposed for a period of not less than the 3 years next preceding. However, the office may waive the 3-year requirement if the insurer provides a product or service not readily available to the consumers of this state or has operated successfully for a period of at least 1 year next preceding and has capital and surplus of not less than $25 million.

(c) Before granting eligibility, the requesting surplus lines agent or the insurer shall furnish the office with a duly authenticated copy of its current annual financial statement in the English language and with all monetary values therein expressed in United States dollars, at an exchange rate (in the case of statements originally made in the currencies of other countries) then-current and shown in the statement, and with such additional information relative to the insurer as the office may request.

(d)1.a. The insurer must have and maintain surplus as to policyholders of not less than $15 million; in addition, an alien insurer must also have and maintain in the United States a trust fund for the protection of all its policyholders in the United States under terms deemed by the office to be reasonably adequate, in an amount not less than $5.4 million. Any such

surplus as to policyholders or trust fund shall be represented by investments consisting of eligible investments for like funds of like domestic insurers under part II of chapter 625 provided, however, that in the case of an alien insurance company, any such surplus as to policyholders may be represented by investments permitted by the domestic regulator of such alien insurance company if such investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of like domestic insurers under part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit issued or confirmed by a qualified United States financial institution, as defined in subparagraph 2., may be used to fund the trust.

b. For those surplus lines insurers that were eligible on January 1, 1994, and that maintained their eligibility thereafter, the required surplus as to policyholders shall be:

(I) On December 31, 1994, and until December 30, 1995, $2.5 million.
(II) On December 31, 1995, and until December 30, 1996, $3.5 million.
(III) On December 31, 1996, and until December 30, 1997, $4.5 million.
(IV) On December 31, 1997, and until December 30, 1998, $5.5 million.
(V) On December 31, 1998, and until December 30, 1999, $6.5 million.
(VI) On December 31, 1999, and until December 30, 2000, $8 million.
(VII) On December 31, 2000, and until December 30, 2001, $9.5 million.
(VIII) On December 31, 2001, and until December 30, 2002, $11 million.
(IX) On December 31, 2002, and until December 30, 2003, $13 million.
(X) On December 31, 2003, and thereafter, $15 million.

c. The capital and surplus requirements as set forth in sub-subparagraph b. do not apply in the case of an insurance exchange created by the laws of individual states, where the exchange maintains capital and surplus pursuant to the requirements of that state, or maintains capital and surplus in an amount not less than $50 million in the aggregate. For an insurance exchange which maintains funds in the amount of at least $12 million for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus in an amount not less than $3 million. If the insurance exchange does not maintain funds in the amount of at least $12 million for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements set forth in sub-subparagraph b.

d. A surplus lines insurer which is a member of an insurance holding company that includes a member which is a Florida domestic insurer as set forth in its holding company registration statement, as set forth in s. 628.801 and rules adopted thereunder, may elect to maintain surplus as to policyholders in an amount equal to the requirements of s. 624.408, subject to the requirement that the surplus lines insurer shall at all times be in compliance with the requirements of chapter 625.

The election shall be submitted to the office and shall be effective upon the office's being satisfied that the requirements of sub-subparagraph d. have been met. The initial date of election shall be the date of office approval. The election approval application shall be on a form adopted by commission rule. The office may approve an election form submitted pursuant to sub-subparagraph d. only if it was on file with the former Department of Insurance before February 28, 1998.

2. For purposes of letters of credit under subparagraph 1., the term "qualified United States financial institution" means an institution that:

a. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state.

b. Is regulated, supervised, and examined by authorities of the United States or any state having regulatory authority over banks and trust companies.

c. Has been determined by the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and

standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit are acceptable to the office.

(e) The insurer must be of good reputation as to the providing of service to its policyholders and the payment of losses and claims.

(f) The insurer must be eligible, as for authority to transact insurance in this state, under s. 624.404(3).

(g) This subsection does not apply as to unauthorized insurers made eligible under s. 626.917 as to wet marine and aviation risks.

(3) The office shall from time to time publish a list of all currently eligible surplus lines insurers and shall mail a copy thereof to each licensed surplus lines agent at his or her office of record with the office.

(4) This section shall not be deemed to cast upon the office any duty or responsibility to determine the actual financial condition or claims practices of any unauthorized insurer; and the status of eligibility, if granted by the office, shall indicate only that the insurer appears to be sound financially and to have satisfactory claims practices and that the office has no credible evidence to the contrary.

(5) When it appears that any particular insurance risk which is eligible for export, but on which insurance coverage, in whole or in part, is not procurable from the eligible surplus lines insurers, after a search of eligible surplus lines insurers, then the surplus lines agent may file a supplemental signed statement setting forth such facts and advising the office that such part of the risk as shall be unprocurable, as aforesaid, is being placed with named unauthorized insurers, in the amounts and percentages set forth in the statement. Such named unauthorized insurer shall, however, before accepting any risk in this state, deposit with the department cash or securities acceptable to the office and department of the market value of $50,000 for each individual risk, contract, or certificate, which deposit shall be held by the department for the benefit of Florida policyholders only; and the surplus lines agent shall procure from such unauthorized insurer and file with the office a certified copy of its statement of condition as of the close of the last calendar year. If such statement reveals, including both capital and surplus, net assets of at least that amount required for licensure of a domestic insurer, then the surplus lines agent may proceed to consummate such contract of insurance. Whenever any insurance risk, or any part thereof, is placed with an unauthorized insurer, as provided herein, the policy, binder, or cover note shall contain a statement signed by the insured and the agent with the following notation: "The insured is aware that certain insurers participating in this risk have not been approved to transact business in Florida nor have they been declared eligible as surplus lines insurers by the Office of Insurance Regulation of Florida. The placing of such insurance by a duly licensed surplus lines agent in Florida shall not be construed as approval of such insurer by the Office of Insurance Regulation of Florida. Consequently, the insured is aware that the insured has severely limited the assistance available under the insurance laws of Florida. The insured is further aware that he or she may be charged a reasonable per policy fee, as provided in s. 626.916(4), Florida Statutes, for each policy certified for export." All other provisions of this code shall apply to such placement the same as if such risks were placed with an eligible surplus lines insurer.

(6) When any particular insurance risk subject to subsection (5) is eligible for placement with an unauthorized insurer and not more than 12.5 percent of the risk is so subject, the office may, at its discretion, permit the agent to obtain from the insured a signed statement as indicated in subsection (5). All other provisions of this code apply to such placement the same as if such risks were placed with an eligible surplus lines insurer.

624.307 General powers; duties.—

69P-5.002 thru .012
Rulemaking Authority

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

626.914 Definitions.—As used in this Surplus Lines Law, the term:
(1) "Surplus lines agent" means an individual licensed as provided in this part to handle the placement of insurance coverages with unauthorized insurers and to place such coverages with authorized insurers as to which the licensee is not licensed as an agent.
(2) "Eligible surplus lines insurer" means an unauthorized insurer which has been made eligible by the office to issue insurance coverage under this Surplus Lines Law.
(3) "To export" means to place, in an unauthorized insurer under this Surplus Lines Law, insurance covering a subject of insurance resident, located, or to be performed in this state.
(4) "Diligent effort" means seeking coverage from and having been rejected by at least three authorized insurers currently writing this type of coverage and documenting these rejections. However, if the residential structure has a dwelling replacement cost of $1 million or more, the term means seeking coverage from and having been rejected by at least one authorized insurer currently writing this type of coverage and documenting this rejection.

626.913 Surplus Lines Law; short title; purposes.—
(2) It is declared that the purposes of the Surplus Lines Law are to provide orderly access for the insuring public of this state to insurers not authorized to transact insurance in this state, through only qualified, licensed, and supervised surplus lines agents resident in this state, for insurance coverages and to the extent thereof not procurable from authorized insurers; to protect such authorized insurers, who under the laws of this state must meet certain standards as to policy forms and rates, from unwarranted competition by unauthorized insurers who, in the absence of this law, would not be subject to similar requirements; and for other purposes as set forth in this Surplus Lines Law.

626.915 Surplus lines insurance authorized.—If certain insurance coverages of subjects resident, located, or to be performed in this state cannot be procured from authorized insurers, such coverages, hereinafter designated "surplus lines," may be procured from unauthorized insurers, subject to the following conditions:
(1) The insurance must be eligible for export under s. 626.916 or s. 626.917;
(2) The insurer must be an eligible surplus lines insurer under s. 626.917 or s. 626.918;
(3) The insurance must be so placed through a licensed Florida surplus lines agent; and
(4) The other applicable provisions of this Surplus Lines Law must be met.

626.924 Information required on contract.—
(1) Each surplus lines agent through whom a surplus lines coverage is procured shall write or print on the outside of the policy and on any certificate, cover note, or other confirmation of the insurance his or her name, address, and identification number and the name and address of the producing agent through whom the business originated and shall have stamped or written upon the first page of the policy or the certificate, cover note, or confirmation of insurance the words: THIS INSURANCE IS ISSUED PURSUANT TO THE FLORIDA SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF THE FLORIDA INSURANCE GUARANTY ACT TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.
(2) Surplus lines policies issued on or after October 1, 2009, shall have stamped or printed on the face of the policy in at least 14-point, boldface type, the following statement: SURPLUS LINES INSURERS' POLICY RATES AND FORMS ARE NOT APPROVED BY ANY FLORIDA REGULATORY AGENCY.

626.930 Records of surplus lines agent.—
(1) Each surplus lines agent shall keep in his or her office in this state, or in the agent's state of residence for a nonresident who does not have an office in this state, a full and true record for a period of 5 years of each surplus lines contract, including applications and all certificates, cover notes, and other forms of confirmation of insurance coverage and any substitutions thereof or endorsements thereto relative to said contract procured by the agent and showing such of the following items as may be applicable:
(a) Amount of the insurance and perils insured against;
(b) Brief general description of property insured and where located;
(c) Gross premium charged;
(d) Return premium paid, if any;
(e) Rate of premium charged upon the several items of property;
(f) Effective date of the contract, and the terms thereof;
(g) Name and post office address of the insured;
(h) Name and home-office address of the insurer;
(i) Amount collected from the insured; and
(j) Other information as may be required by the department.
(2) The record shall at all times be open to examination by the department or the Florida Surplus Lines Service Office without notice and shall be so kept available and open for 5 years next following expiration or cancellation of the contract.
(3) Each surplus lines agent shall maintain all surplus lines business records in his or her general lines agency office, if licensed as a general lines agent, or in his or her managing general agency office, if licensed as a managing general agent or the full-time salaried employee of such general agent.

626.929 Origination, acceptance, placement of surplus lines business.—
(1) A general lines agent while licensed and appointed as a surplus lines agent under this part may originate surplus lines business and may accept surplus lines business from any other originating Florida-licensed general lines agent appointed and licensed as to the kinds of insurance involved and may compensate such agent therefor.

626.931 Agent affidavit and insurer reporting requirements.—
(1) Each surplus lines agent shall on or before the 45th day following each calendar quarter file with the Florida Surplus Lines Service Office an affidavit, on forms as prescribed and furnished by the Florida Surplus Lines Service Office, stating that all surplus lines insurance transacted by him or her during such calendar quarter has been submitted to the Florida Surplus Lines Service Office as required.
(2) The affidavit of the surplus lines agent shall include efforts made to place coverages with authorized insurers and the results thereof.
(3) Each foreign insurer accepting premiums shall, on or before the end of the month following each calendar quarter, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during such calendar quarter.
(4) Each alien insurer accepting premiums shall, on or before June 30 of each year, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during the preceding calendar year.
(5) The department may waive the filing requirements described in subsections (3) and (4).
(6) Each insurer's report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on

forms prescribed by the Florida Surplus Lines Service Office and shall show for each applicable agent:

(a) A listing of all policies, certificates, cover notes, or other forms of confirmation of insurance coverage or any substitutions thereof or endorsements thereto and the identifying number; and

(b) Any additional information required by the department or Florida Surplus Lines Service Office.

626.938 Report and tax of independently procured coverages.—

(1) Every insured who in this state procures or causes to be procured or continues or renews insurance from another state or country with an unauthorized foreign or alien insurer legitimately licensed in that jurisdiction, or any self-insurer who in this state so procures or continues excess loss, catastrophe, or other insurance, upon a subject of insurance resident, located, or to be performed within this state, other than insurance procured through a surplus lines agent pursuant to the Surplus Lines Law of this state or exempted from tax under s. 626.932(4), shall, within 30 days after the date such insurance was so procured, continued, or renewed, file a report of the same with the Florida Surplus Lines Service Office in writing and upon forms designated by the Florida Surplus Lines Service Office and furnished to such an insured upon request, or in a computer readable format as determined by the Florida Surplus Lines Service Office. The report shall show the name and address of the insured or insureds, the name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged therefor, and such additional pertinent information as is reasonably requested by the Florida Surplus Lines Service Office.

(2) Any insurance on a risk located in this state in an unauthorized insurer legitimately licensed in another state or country procured through solicitations, negotiations, or an application occurring or made outside this state shall be deemed to be insurance procured, continued, or renewed in this state within the intent of subsection (1).

(3) For the general support of the government of this state, there is levied upon the obligation, chose in action, or right represented by the premium charged for such insurance a tax at the rate of 5 percent of the gross amount of such premium and a 0.3 percent service fee pursuant to s. 626.9325. If the policy covers risks or exposures only partially in this state and this state is the home state as defined by the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), the tax and service fee payable shall be computed on the gross premium. The tax must not exceed the tax rate where the risk or exposure is located. The insured shall withhold the amount of the tax and service fee from the amount of premium charged by and otherwise payable to the insurer for such insurance. On or before the 45th day following each calendar quarter after the insurance is procured, continued, or renewed, the insured shall make payable to the department the amount of the tax and make payable to the Florida Surplus Lines Service Office the amount of the service fee. The insured shall remit the tax and the service fee to the Florida Surplus Lines Service Office. The Florida Surplus Lines Service Office shall forward to the department the taxes, and any interest collected pursuant to subsection (5), within 10 days after receipt.

(4) If the insured fails to withhold from the premium the amount of tax and the service fee herein levied, the insured shall be liable for the amount thereof and shall pay that amount to the Florida Surplus Lines Service Office within the time stated in subsection (3).

(5) The tax imposed hereunder, if delinquent, shall bear interest at the rate of 6 percent per year, compounded annually.

(6) The tax shall be collectible from the insured by civil action brought by the department or by distraint.

[1](7) Taxes and interest collected under this section shall be deposited into the General Revenue Fund.

(8) This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify, any provision of s. 626.901, s. 626.902, s. 626.903, or any other provision of this code.

(9) This section does not authorize independent procurement of workers' compensation insurance, life insurance, or health insurance.

(10) Each report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on forms prescribed by the Florida Surplus Lines Service Office.

History.—s. 377, ch. 59-205; s. 9, ch. 63-86; s. 16, ch. 65-269; ss. 13, 35, ch. 69-106; s. 2, ch. 81-318; ss. 316, 318, 807, ch. 82-243; s. 47, ch. 90-132; ss. 181, 206, 207, ch. 90-363; s. 4, ch. 91-429; s. 35, ch. 92-146; s. 12, ch. 2001-213; s. 1026, ch. 2003-261; s. 9, ch. 2003-395; s. 9, ch. 2006-305; s. 5, ch. 2008-132; ss. 8, 9, ch. 2009-70; s. 5, ch. 2011-46.

[1]Note.—Section 9, ch. 2009-70, provides that "[t]he amendments to ss. 626.932(5) and 626.938(7), Florida Statutes, made by this act expire July 1, 2014, and the text of those subsections shall revert to that in existence on June 30, 2009, except that any amendments to such text enacted other than by this act shall be preserved and continue to operate to the extent that such amendments are not dependent upon the portions of such text which expire pursuant to this section." Effective July 1, 2014, subsection (7), as amended by s. 9, ch. 2009-70, will read:

(7) The department shall deposit 15.74 percent of all taxes and interest collected under this section to the credit of the Insurance Regulatory Trust Fund. Eighty-four and twenty-six hundredths percent of all taxes and interest collected under this section shall be deposited into the General Revenue Fund.

626.621 Grounds for discretionary refusal, suspension, or revocation of agent's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.—The department may, in its discretion, deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, adjuster, customer representative, service representative, or managing general agent, and it may suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist under circumstances for which such denial, suspension, revocation, or refusal is not mandatory under s. 626.611:

(7) Willful overinsurance of any property or health insurance risk.

627.949 Restrictions on insurance purchased by purchasing groups.—

(1) In order to purchase insurance or coverage for a risk located in this state, which risk is a subject of insurance of a member of the purchasing group, a purchasing group shall only purchase insurance or coverage from:

(a) A risk retention group that is certificated or licensed in one of the states of the United States;

(b) An authorized insurer; or

(c) An eligible surplus lines insurer.

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(e), to a limit of $10,000 for loss sustained

by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. However, the medical benefits shall provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following persons or entities:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under ss. 400.990-400.995 that is:

a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) Disability benefits.—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision shall be paid not less than every 2 weeks.

(c) Death benefits.—Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

627.944 Risk retention groups not certificated in this state.—Risk retention groups certificated or licensed in states other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:
(3) TAXATION.—All premiums paid for insurance or coverages on risks located within this state to a risk retention group shall be subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to eligible surplus lines insurers. Each agent utilized in any transaction shall report and pay the taxes for the premiums for risks which they have placed with or on behalf of a risk retention group not certificated in this state. In the event that an agent fails to pay the tax, each risk retention group shall pay the tax for insured or covered risks located within this state. Further, each risk retention group shall report all premiums paid to it for insured or covered risks located within this state.

# M E M O R A N D U M

**DATE:** January 5, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy
Stephen Fredrickson

**SUBJECT:** Cabinet Agenda for February 7, 2017
Request for Approval to Publish Repeal to
Rule 69O-128.025
Assignment # 199866-16

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before February 1, 2017 and to the Financial Services Commission on February 7, 2017, with a request to approve for publication the proposed rule.

This rule defines "personal financial and health information" as used in Section 624.23, F. S. The rule is being repealed because it is inconsistent with the definition provided in the statute.

Sections 624.308(1), 624.23, 624.307(1) F.S., provide rulemaking authority and laws implemented for this rule.

Monica Ross is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

**69O-128.025 Confidentiality of Personal Financial and Health Information Pursuant to Section 624.23, F.S.**

*Rulemaking Authority 624.308(1) FS. Law Implemented 624.23, 624.307(1) FS. History–New 10-21-02, Formerly 4-128.02, Repealed_____.*

69O-128.025 Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.23 Public records exemption.—

(1) As used in this section, the term:

(a) "Consumer" means:

1. A prospective purchaser, purchaser, or beneficiary of, or applicant for, any product or service regulated under the Florida Insurance Code, and a family member or dependent of a consumer.

2. An employee seeking assistance from the Employee Assistance and Ombudsman Office under s. 440.191.

(b) "Personal financial and health information" means:

1. A consumer's personal health condition, disease, or injury;

2. A history of a consumer's personal medical diagnosis or treatment;

3. The existence, nature, source, or amount of a consumer's personal income or expenses;

4. Records of or relating to a consumer's personal financial transactions of any kind;

5. The existence, identification, nature, or value of a consumer's assets, liabilities, or net worth;

6. The existence or content of, or any individual coverage or status under a consumer's beneficial interest in, any insurance policy or annuity contract; or

7. The existence, identification, nature, or value of a consumer's interest in any insurance policy, annuity contract, or trust.

(2) Personal financial and health information held by the department or office relating to a consumer's complaint or inquiry regarding a matter or activity regulated under the Florida Insurance Code or s. 440.191 are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This exemption applies to personal financial and health information held by the department or office before, on, or after the effective date of this exemption.

(3) Such confidential and exempt information may be disclosed to:

(a) Another governmental entity, if disclosure is necessary for the receiving entity to perform its duties and responsibilities.

(b) The National Association of Insurance Commissioners.

(c) The consumer or the consumer's legally authorized representative.

624.307 General powers; duties.—

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy
Stephen Fredrickson

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Rule 69O-138.001
Assignment # 203213-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

These rules are being amended to adopt the 2016 and 2017 NAIC Financial Condition Examiners Handbooks. The current rule adopted the 2015 and 2016 versions of these handbooks.

Sections 624.308(1), 624.316(1)(c), F.S., provide rulemaking authority and laws implemented for these rules.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy
Stephen Fredrickson

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Rule 69O-137.001
Assignment # 203111-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

These rules are being amended to adopt the 2017 NAIC Quarterly Statement Manuals, the 2016 NAIC Annual Statement Instructions Manuals, the 2016 and 2017 NAIC Accounting Practices and Procedures Manuals and 2017 NAIC User's Guide. The current rule adopted the 2016 NAIC Quarterly Statement Manuals, the 2015 NAIC Annual Statement Instructions Manuals, and the 2015 and 2016 NAIC Accounting Practices and Procedures Manuals.

Sections 624.308(1), 624.424(1), F.S., provide rulemaking authority and laws implemented for these rules.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

**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 2017 ~~2016~~) are hereby adopted and incorporated by reference, https://www.flrules.org/Gateway/reference.asp?No=Ref-05718.

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, 2016 ~~2015~~;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 2016 ~~2015~~;

**69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.**

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2017 ~~2016~~ is hereby adopted and incorporated by reference.

(b) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2016 ~~2015~~ 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 Amended_____.*

**624.308 Rules.--**

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

**624.424 Annual statement and other information.--**

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

**624.308 Rules.--**

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

**624.316 Examination of insurers.--**

(1)(c) The office shall examine each insurer according to accounting procedures designed to fulfill the requirements of generally accepted insurance accounting principles and practices and good internal control and in keeping with generally accepted accounting forms, accounts, records, methods, and practices relating to insurers. To facilitate uniformity in examinations, the commission may adopt, by rule, the Market Conduct Examiners Handbook and the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners, 2002, and may adopt subsequent amendments thereto, if the examination methodology remains substantially consistent.

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy VC
Stephen Fredrickson SF

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Electronic Filing Rules P&C Financial Oversight
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

The various rules indicate how forms and filings are to be made to the Office. These rule revisions update the rules to reflect the electronic fling process and in some cases the forms have been updated to reflect current practice.

Sections 624.308(1), 624.4085,624.4243, 624.424(8)(e),(10), 624.307(1), 624.324, 624.610(11), 624.316, 624.3161, 624.320, 624.321(1), 624.424, 625.121(3), 625.331, 624.80, 624.81, 625.012, 625.172, 625.302, 625.330, 625.332, 625.338, 624.610 , F.S., provide rulemaking authority and laws implemented for these rules.

SF Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy VC
Stephen Fredrickson SF

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Rules for Electronic Filing Life and Health
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

The various rules indicate how forms and filings are to be made to the Office. These rule revisions update the rules to reflect the electronic fling process and in some cases the forms have been updated to reflect current practice.

Sections 624.308(1), 624.307, 627.6699, 624.424, 627.6475, 627.6692(9)(5), 627.674, 641.36, 627.307,627.410, 627.6425, 627.6487(9),627.6571, 641.31074, 627.673, 627.6735, 627.6741, 627.6745, 627.6746, 627.6785, 627.682, 641.31, 641.36, 627.413(4), 627.4145,

F.S., provide rulemaking authority and laws implemented for these rules.

SCF Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy VC
Stephen Fredrickson SF

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Rules 69O-157.111 and 69O-167.002
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

The various rules indicate how forms and filings are to be made to the Office. These rule revisions update the rules to reflect the electronic filing process and in some cases the forms have been updated to reflect current practice.

Sections 624.308(1), 627.9407(1), 627.9408, 624.307(1), 624.424, 627.9402, 627.410(7), 626.9541(1)(o)3.a., 627.420, 627.421,627.728,627.7282, F.S., provide rulemaking authority and laws implemented for these rules.

SF Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy
Stephen Fredrickson

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Electronic Filing Rules for P&C Product Review
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

The various rules indicate how forms and filings are to be made to the Office. These rule revisions update the rules to reflect the electronic fling process and in some cases the forms have been updated to reflect current practice.

Sections 624.308(1), 627.331, 624.307(1), 624.418, 624.4211, 624.424(6), 627.062, 627.171, 627.4143, 627.701, 624.424, 624.604, 624.605, 627.0629(1), 627.0645, 627.0651, 627.221, 627.301 F.S., provide rulemaking authority and laws implemented for these rules.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

**69O-149.039 Designation of Election to Become a Risk-Assuming or Reinsuring Carrier Under Section 627.6699, Florida Statutes, the Employee Health Care Access Act.**

(1) A small employer carrier shall file, pursuant to paragraph 69O-149.044(2)(b), F.A.C., a final designation of election to become either a risk-assuming carrier or a reinsuring carrier using Form OIR-B2-1093, "State of Florida/Small Employer Carrier's Application to Become a Risk Assuming Carrier or a Reinsuring Carrier, as Required by Section 627.6699(9), F.S.," adopted in Rule 69O-149.044, F.A.C.

(2) The Office shall provide notice by publication of a small employer carrier's designation of election to become a risk assuming carrier and shall provide 21 days from publication for comment prior to making a decision on the election. The Office shall hold a hearing on the election if requested by the carrier.

(3) The Office shall approve or disapprove any application within 60 days after filing, based on the criteria in Section 627.6699(10), F.S.

(4) The filing shall be submitted to the Office electronically through http://www.floir.com/iportal.

*Rulemaking Authority 627.6699(16) FS. Law Implemented 624.424, 627.6699(9), (10) FS. History–New 3-1-93, Amended 11-7-93, 8-4-02, Formerly 4-149.039 Amended_____.*

**69O-149.040 Change of Status of Small Employer Carrier's Election to Become Risk-Assuming Carrier or Reinsuring Carrier.**

(1) Any small employer carrier seeking to change the election made by the carrier under Section 627.6699(9)(a), F.S., to become either a risk-assuming carrier or a reinsuring carrier shall request a change of status, pursuant to paragraph 69O-149.044(2)(b), F.A.C., on Form OIR-B2-1095, State of Florida/Small Employer Carrier's Application to Modify Previous Election to Become a Risk Assuming or a Reinsuring Carrier, As Required by Section 627.6699(9), F.S., adopted in Rule 69O-149.044, F.A.C.

(2) Within 60 days after the form and its attached information is filed with the Office, the Office will hold a hearing on the request. Within 30 days after the conclusion of the hearing and the submission of any post-hearing documentation or argument, the Office will approve or disapprove the request, based on the criteria in Section 627.6699(10)(b), F.S.

(3) The filing shall be submitted to the Office electronically through http://www.floir.com/iportal.

*Rulemaking Authority 627.6699(9)(b), (16) FS. Law Implemented 624.424, 627.6699(9), (10), (11) FS. History–New 3-1-93, Amended 11-7-93, 8-4-02, Formerly 4-149.040, Amended _____.*

**69O-149.043 Small Employer Health Reinsurance Program.**

(1) Beginning January 1, 1994, the board of the "Florida Small Employer Health Reinsurance Program," as established in Section 627.6699(11), F.S., shall consist of the Director or his designee, who shall serve as chairman, and eight (8) additional members who are representatives of carriers and who are appointed by the commissioner in accordance with the requirements of Sections 627.6699(11)(b)3. and 6., F.S., with the restrictions in Section 627.6699(11)(b)3.a., F.S., and with this rule.

(2) Of the 8 additional members of the board, subsequently amended to 13 in the 2000 legislative session, 5 shall be selected from individuals recommended by small employer carriers. Any small employer carrier wishing to do so may submit a list of recommended appointees to the commissioner either on its own behalf or through its trade organization. The list shall be submitted to: Insurance Commissioner ~~Chief, Bureau of Life and Health Forms & Rates~~, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0328 or submitted electronically to InsuranceCommissioner@floir.com. ~~ihfrbureau@dfs.state.fl.us.~~ The carrier or trade organization submitting the list shall include the following information about the persons it is recommending:

(a) Name, present affiliation, business address and business phone number.

(b) Educational background to the extent the small employer carrier deems it relevant to the selection process.

(c) Work experience to the extent the small employer carrier deems it relevant to the selection process.

(d) Professional qualifications not addressed in paragraphs (b) and (c), above, such as membership in professional societies and publications, to the extent the small employer carrier deems it relevant to the selection process.

*Rulemaking Authority 624.308(1), 627.6699(16) FS. Law Implemented 624.424, 627.6699(11) FS. History–New 11-7-93, Amended 8-4-02, 6-19-03, Formerly 4-149.043, Amended_____.*

**69O-154.114 Withdrawal From the Individual Market.**

(1) If a health insurance issuer elects to withdraw from the individual health insurance market, the issuer must provide 180 days' written notice to the Office and to all policyholders, certificateholders and beneficiaries provided coverage by the issuer in that market.

(2) A notice of withdrawal from the individual market means an issuer may then non-renew coverage upon the next renewal date of policies affected by the withdrawal.

(3) A policy may not be terminated except at the next renewal date following the 180 day notice period.

(4) Notice to the Office must include a copy of all forms issued in that market.

(5) With respect to notice to policyholders, certificateholders, beneficiaries, a mailing to one household constitutes a mailing to all covered persons residing in the household.

(6) A separate mailing is required for each separate household.

(7) If the issuer elects to exit or withdraw from the individual market, re-entry into that market is prohibited for five years from the last date of coverage provided in that market.

(8) The filing shall be submitted to the Office electronically through http://www.floir.com/iportal.

*Rulemaking Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.307, 627.6425 FS. History–New 3-1-98, Formerly 4-154.114, Amended_____.*

**69O-154.305 Election and Premium Notice Form.**

(1) Within 14 days of the date that the carrier receives the notice of occurrence of a qualifying event from the qualified beneficiary the carrier must send to the employee, covered spouse and covered dependents, by certified mail, the Election and Premium Notice Form OIR-B2-1261 (REV 8/03), which is hereby adopted and incorporated by reference. Copies of the forms are available and may be printed from the Office's website: http://www.floir.com/iportal ~~http://www.floir.com/lh_fr/is_lhfr_Statutory%20Form%20and%20%20Reporting.htm.~~

(2) Carriers may develop a similar form which must include the information in Form OIR-B2-1261. Any similar form must be filed and approved before use pursuant to the requirements of Section 627.410, F.S. Any filing shall be submitted to the Office electronically through http://www.floir.com/iportal.

*Rulemaking Authority 624.308(1), 627.6692(9) FS. Law Implemented 624.307(1), 624.424, 627.6692(5) FS. History–New 4-24-97, Formerly 4-154.305, Amended 5-4-06, Amended_____.*

**69O-154.410 Withdrawal From the Group Market.**

(1) If a health insurance issuer elects to withdraw from the group market, the issuer must provide 180 days' written notice to the Office and to all policyholders, certificateholders and beneficiaries provided coverage by the issuer in that market.

(2) A notice of withdrawal from the group market means an issuer may then non-renew coverage upon the next renewal date of policies affected by the withdrawal.

(3) A policy may not be terminated except at the next renewal date following the 180 day notice period.

(4) Notice to the Office must include a copy of all forms issued in that market.

(5) With respect to notice to policyholders, certificateholders, beneficiaries, a mailing to one household constitutes a mailing to all covered persons residing in the household.

(6) A separate mailing is required for each separate household.

(7) If the issuer elects to exit or withdraw from the group market, re-entry into that market is prohibited for five years from the last date of coverage provided in that market.

(8) The filing shall be submitted to the Office electronically through http://www.floir.com/iportal.

*Rulemaking Authority 624.308(1), 641.36 FS. Law Implemented 624.424, 627.307, 627.410, 627.6571(3)(b), 641.31074 FS. History–New 3-1-98, Formerly 4-154.410, Amended_____.*

**69O-154.512 Withdrawal From the Small Group Market.**

(1) If a small employer carrier elects to withdraw from the small group health insurance market, the carrier must provide 180 days' written notice to the Office and to all policyholders, certificateholders and beneficiaries provided coverage by the carrier in that market.

(2) A notice of withdrawal from the small group market means an issuer may then non-renew coverage upon the next renewal date of policies affected by the withdrawal.

(3) A policy may not be terminated except at the next renewal date following the 180 day notice period.

(4) Notice to the Office must include a copy of all forms issued in that market.

(5) With respect to notice to policyholders, certificateholders, beneficiaries, a mailing to one household constitutes a mailing to all covered persons residing in the household.

(6) A separate mailing is required for each separate household.

(7) If the small employer carrier elects to exit or withdraw from the small group market, re-entry into that market is prohibited for five years from the last date of coverage provided in that market.

(8) The filing shall be submitted to the Office electronically through http://www.floir.com/iportal.

*Rulemaking Authority 624.308(1) FS. Law Implemented 624.424, 627.307, 627.410, 627.6571 FS. History–New 3-1-98, Formerly 4-154.51, Amended _____.*

**69O-191.051 Filing, Approval of Subscriber Contract and Related Forms.**

(1) Every subscriber group, individual, or conversion contract and every rider, endorsement, certificate, application or other forms (including the initial subscriber communication outlining their rights and responsibilities under the grievance process) to be used or issued in connection with any subscriber contract shall be filed by the HMO for approval by the Office. The form may be used immediately upon filing, but is subject to disapproval by the Office. If disapproved, use of the form shall be discontinued immediately. Documentation evidencing any proposed rates or rate changes as required in Rule 69O-191.054, F.A.C., shall accompany the form filing for approval by the Office.

(2) Every form required to be filed by the HMO shall be identified by a unique form number, placed in the lower left hand corner of each form.

(3)~~(a)~~ One copy of each form filing shall be submitted at the time of filing. HMOs in possession of a Certificate of Authority shall submit all contract filings to the Office electronically through http://www.floir.com/iportal. ~~Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, Post Office Box 8040, Tallahassee, Florida 32301-8040, or submitted electronically to https://iportal.fldfs.com. All filings sent by Federal Express or any other form of special delivery shall be delivered to: Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328.~~

~~(b) Subsequent to July 1, 2003, all filings shall be submitted electronically to https://iportal.fldfs.com, or by computer diskette meeting the compatibility requirements mandated by Section 624.424(1)(c), F.S. Deadlines for filing will not be extended due to shipping delays, format incompatibility, data corruption, or any other impediment which results from an election to file by diskette.~~

(4)(a) Each HMO shall provide one copy of a written informed consent notice used to disclose the intent of testing a person for HIV infection or other specific sickness as required in Section 641.3007(4)(b), F.S. The form shall include the following:

1. Explanation of the testing;

2. Purpose of the test;

3. Potential uses of the form information and limitations;

4. The meaning of the test results; and

5. Person's rights to confidential treatment of the information obtained.

(b) The HMO is required to establish a procedure for notifying the applicant's designated physician of a positive test result and in the absence of such designation, by the Florida Office of Health and Rehabilitative Services (DHRS). Positive HIV test results should be transmitted to DHRS in the following manner, when necessary:

(5) Each HMO shall include a copy of the following forms:

(a) Form OIR-B2-1507, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter" as adopted in Rule 69O-149.022, F.A.C., completely filled out in accordance with Form OIR-B2-1507A, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", as adopted in Rule 69O-149.022, F.A.C.

(b) Form DI4-1356, The Office of Insurance Regulation, Florida HMO Contract Checklist (Includes Individual, Large and Small Group), as adopted in Rule 69O-149.022, F.A.C.

*Rulemaking ~~Specific~~ Authority 641.36 FS. Law Implemented 624.424, 641.21(1)(e), 641.3007(4)(b), (c), 641.31(2), (3) FS. History–New 2-22-88, Amended 10-25-89, Formerly 4-31.051, Amended 5-28-92, 8-15-02, 6-19-03, Formerly 4-191.051 Amended_____.*

69O-191.054 **Rates.**

(1) Before charging or quoting premiums to subscribers, an HMO shall file for approval the rating methodology by which those premiums were determined with the Office.

(a) All materials submitted shall be legible. A filing which is illegible or which contains illegible material will be disapproved without any further processing.

(b) For purposes of this rule, Rule 69O-191.055, F.A.C., and the time periods established in Section 641.31, F.S., a filing is considered "filed" with the Office upon receipt of the material required in paragraph (2)(a), below. For purposes of this rule and Rule 69O-191.055, F.A.C., the term "filed" does not mean "approved".

(2) Filings of rating methodologies shall provide adequate information, so that the Office, in accordance with generally accepted actuarial principles as applied to Health Maintenance Organizations, may verify that the rating methodology does not produce inadequate, excessive, or unfairly discriminatory premiums. All rate classifications should be clearly identified, and the formulas and/or methods of calculating premiums adequately described, as defined in Rule 69O-191.055, F.A.C.

(a) The components of HMO rate filings shall consist of one copy of all of the items in subparagraphs 1. through 4. Filings for small group coverage subject to Section 627.6699, F.S., shall additionally comply with the provisions of Part III of Chapter 69O-149, F.A.C.

1. A brief letter explaining the type and nature of the filing. The letter shall indicate if the filing is for a new product, a rate revision or a resubmission. If the filing is a resubmission, the letter should indicate when the previous filing was submitted, the Florida filing number, and the date of the disapproval.

2. The Actuarial Memorandum, completed as required in Rule 69O-191.055, F.A.C.

3. Rate pages which define all proposed rates, rating factors, and methodologies for determining rates applicable in the state.

4. Form OIR-B2-1507, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter", as adopted in Rule 69O-149.022, F.A.C., completely filled out in accordance with Form OIR-B2-1507A, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", as adopted in Rule 69O-149.022, F.A.C.

(b) Filings, as that term is defined in paragraph (a), shall be submitted to the Office electronically through http://www.floir.com/iportal. ~~mailed to: Office of Insurance Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, Post Office Box 8040, Tallahassee, Florida 32301-8040 or submitted electronically to https://iportal.fldfs.com. All filings sent to the Office by Federal Express or any other form of special delivery shall be delivered to: Office of Insurance~~

~~Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328.~~

(c)1. Every HMO submitting a rate filing shall be notified as to whether the filing has been affirmatively approved by the Office, or has been disapproved by the Office, including disapprovals for failure of the material to meet the definition of a "filing" or for illegibility, within any statutory review period of the date of receipt of the filing.

2. Every HMO submitting a rate filing which does not comply with the requirement of Rules 69O-191.054 and 69O-191.055, F.A.C., or for which the Office determines that additional information is necessary for a proper review, will be notified of the additional information necessary within the statutory time limit.

3. Every HMO shall submit the required data by a date certain stated in the clarification letter to allow the Office sufficient time to perform a proper review.

4. Failure to correct the filing by the date certain in the clarification letter will result in an affirmative disapproval of the filing by the Office.

(3) For individual (non-group) subscribers, it should be possible for the Office, using the filed rating methodology, to verify any premiums charged or quoted. For group subscribers not subject to experience rating, the HMO shall be able to demonstrate that any premiums charged or quoted were derived from the filed rating methodology in an actuarially sound manner. For group subscribers subject to experience rating, the HMO shall be able to demonstrate that the premiums charged or quoted were consistent with the filed rating methodology.

(4) In order that the above verification may be more readily accomplished, for one year from the effective date of the contract, HMOs shall maintain worksheets showing in detail the calculation of the premiums charged to each group subscriber. Such worksheets shall contain at least the following information:

(a) For experience-rated groups, the calculation of the per member per month revenue requirements;

(b) For groups not subject to experience rating, the applicable per member per month revenue requirement;

(c) A description of the development of the assumed employee and dependent composition of each tier of rates;

(d) A summary showing how the per member per month revenue requirements, employee and dependent composition, and the selected ratios between tiers of rates produces the premiums charged to a group.

(5) HMOs with fewer than 1,000 Florida subscribers, for all individual forms combined or for all group forms combined, may, at their option, file a streamlined annualized rate increase filing not exceeding medical trend as provided in subsection 69O-149.003(7), F.A.C. The filing shall be made in accordance with paragraph 69O-191.054(2)(a), F.A.C., with a certification that the

filing includes all individual forms or all group forms in lieu of the actuarial memorandum required by Rule 69O-191.055, F.A.C.

(6)(a) Rates for group conversion contracts, issued on a group or on an individual basis are exempt from the loss ratio requirements below. The loss ratio for group conversion contracts shall not be less than 120 percent. The premium for a converted contract may not exceed 200 percent of the standard risk rate, as published in Chapter 69O-149, Part X, F.A.C.

(b) Rates for contracts, including riders and endorsements, issued to individual (non-group) subscribers shall be deemed excessive if anticipated loss ratios for such contracts are less than 70%.

(c) Rates for contracts, including riders and endorsements, issued to group subscribers shall be deemed excessive if target loss ratios anticipated over the rating period for such contracts are less than the following:

| Group Size | Loss Ratio |
|---|---|
| 51 to 100 | 70% |
| 101 to 500 | 75% |
| over 500 | 80% |

(d) Rates filed for approval that are anticipated to result in an actual to expected ratio over the rating period which is less than 1.0 shall be deemed to be excessive.

(e) Rates for contracts providing home health care coverage pursuant to Section 641.2018, F.S., shall comply with the provisions of Chapters 69O-157 and 69O-149, F.A.C.

(7) Rates are inadequate if:

(a) The premiums derived from the rating structure, plus investment income, co-payments, and revenues from coordination of benefits and subrogation, fees-for-service and reinsurance recoveries are not set at a level at least equal to the anticipated cost of medical and hospital benefits, expenses and contingency margin during the period for which the rates are to be effective.

(b) Individual contracts do not incorporate the projected entire effects of insurance trend.

(c) The premium schedule is determined such that if all assumptions are satisfied, the annual rate increase needed will exceed medical trend.

(8) Premiums as to a risk or group of risks are unfairly discriminatory if:

(a) For individual non-group subscribers, the premiums charged deviate from the filed rating methodology.

(b) For group subscribers not subject to experience rating, the premiums charged are designed to produce total revenue for that

group which differs from the revenue requirements for its rating class, as filed with the Office of Insurance Regulation. For group subscribers subject to experience rating, the premiums charged deviate from the filed rating methodology.

(c) The effect of changes to the underlying age/gender slope, reduction in the anticipated loss ratio for the form, and change in the durational slope for individual contract forms, results in subscriber impact greater than 50 percent of medical trend, as defined by subsection 69O-149.003(7), F.A.C., unless phased-in over a 3 year period. A shorter time period shall be considered on a case-by-case basis based on unique situations and justification by the HMO. The HMO, at its option, may request a new business rate schedule based on the full effect of the new assumptions with the phase-in only applicable to existing subscribers.

(d) When an HMO discontinues offering a particular contract form for health insurance coverage pursuant to Section 627.6425(3)(a) or 641.31074(3)(a), F.S., the nonrenewal of coverage shall occur on the contract anniversary, and the offer of new coverage pursuant to Section 627.6425(3)(a)2. or 641.31074(3)(a)2., F.S., shall be considered a renewal of coverage and shall be renewed on the contract anniversary at the same class basis as the coverage being discontinued. If the forms do not have consistent class definitions, the class shall be determined based on the original application and underwriting status of the individual when the discontinued coverage was first issued.

(9) Each HMO shall make an annual filing with the Office for each policy form no later than 12 months after the date of approval of its previous filing for the policy form, demonstrating the reasonableness of benefits in relation to premium rates.

(10) Prohibitions. A premium schedule is unfairly discriminatory if it incorporates any of the following:

(a) Select and Ultimate Premium Schedules are prohibited. Select and ultimate premium schedules are premium schedules that have premiums that vary based on the time elapsed since issuance of the contract.

(b) Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve are prohibited. An attained-age premium schedule is one in which the subscriber's premium rate is dependent upon his or her age at contract renewal. The aging component of the claim cost is not pre-funded. These schedules shall be constructed so that the slope by age is substantially similar to the slope of the ultimate claim cost curve. The premiums must form a smooth progression and, to eliminate jumps in premium caused by bracketed age groups, HMOs shall use each available renewable age. The requirement to use each available renewable age does not apply to any group contract where the final premium charged is an average of the individual members.

(c) Premium structures that provide for retroactive cost determination, or if the subscriber or contract holder participate in the experience under the form.

(11) An HMO may issue multiple year rate guarantee or rating cap provisions subject to the following:

(a) The coverage is for annually rated group health insurance contracts for which filing of rates is exempted by Section 641.31(3)(d), F.S.;

(b) The provision may not apply for greater than 24 months;

(c) The rate for the entire rating period reflects the increased risk of a rate guarantee with an increased premium or other consideration, is actuarially sound, includes claim costs projected at trend levels at least as high as those applicable to other groups with similar benefits structures in the rating area covered under the form(s) and is reasonably anticipated to meet the target loss ratio for the group;

(d) The provision is available to groups on a nondiscriminatory basis as determined by the insurer's underwriting standards; and

(e) The HMO uses experience rating in determining the group's rate consistently based on its rating and underwriting practices without regard to whether the rate is issued with or without a rate guarantee.

*Rulemaking ~~Specific~~ Authority 641.31, 641.36 FS. Law Implemented 624.424, 641.21(1)(e), 641.22(2), (4), (6), 641.31(2), (3), 641.31074, 641.3922(3) FS. History– New 2-22-88, Amended 10-25-89, Formerly 4-31.054, Amended 10-8-96, 8-15-02, 1-19-03, Formerly 4-191.054, Amended 6-18-07, Amended_____.*

**69O-191.075 Annual and Quarterly Reports.**

(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 ~~Bureau of Specialty Insurers, Tallahassee, Florida 32399-0300~~, incorporated in Rule 69O-191.107, F.A.C. ~~The financial statement shall also be filed on a diskette; the Office must approve the electronic format for reporting the financial information.~~ The annual report shall be submitted to the Office electronically through http://www.floir.com/iportal. 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 ~~Bureau of Specialty Insurers, Tallahassee, Florida 32399-0300~~, incorporated herein by reference and also be filed electronically ~~on a diskette~~ 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 ~~Specific~~ Authority 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_____.*

**69O-191.091 Guaranteeing Organizations.**

In order to meet the qualifications for a guaranteeing organization, an entity shall comply with the following:

(1) The guarantor shall comply with Section 641.19(4), F.S., by appointing the Director as its agent for service of process in Florida. The entity must complete a consent form and board resolution approved by the Office and submit originals to the Office of Insurance Regulation, Life and Health Financial Oversight, 200 East Gaines Street, ~~Bureau of Specialty Insurers~~, Tallahassee, Florida 32399-0300.

(2) The guarantor shall comply with Section 641.225(4), F.S., by submitting audited financial statements certified by an independent CPA, prepared in accordance with generally accepted accounting principles, covering the guarantor's two most current annual accounting periods.

(3) The guarantor shall comply with the financial requirements of Section 641.225, F.S., as they relate to surplus requirements.

(4) The guarantor shall execute an appropriate guarantee agreement as required by Section 641.225(4), F.S. The guarantee agreement shall be signed by an officer of the guarantor who has the authority to bind the organization and shall be notarized. The guarantor shall submit the original of the guarantee agreement to the Office. Evidence must be submitted that substantiates the fact that the officer that signs the guarantee agreement has the authority to bind the organization for purposes of executing the guarantee agreement (certified original copy of Board Resolution accompanied by certified original copy of the current Articles of Incorporation and By-Laws of the guarantor).

(5) The guarantor shall maintain continued compliance with Section 641.225, F.S., relating to requirements for guaranteeing organizations, which includes annual financial reporting requirements.

*Rulemaking ~~Specific~~ Authority 641.36 FS. Law Implemented 624.424, 641.19(5), 641.225, 641.285 FS. History–New 2-22-88, Amended 10-25-89, Formerly 4-31.091, Amended 5-28-92, Formerly 4-191.091, Amended_____.*

**69O-191.095 Change of Address.**

Every licensed HMO shall notify the Office of Insurance Regulation, Life and Health Financial Oversight, ~~Bureau of Specialty Insurers,~~ in writing, 60 days prior to such change, of any change in its Florida principal or corporate business address. Any health service clinics or centers owned or controlled by the HMO shall maintain current addresses with the corporate office and shall be made available upon request by the Office.

*Rulemaking ~~Specific~~ Authority 641.36 FS. Law Implemented 624.424, 641.21, 641.221, 641.27 FS. History–New 5-28-92, Formerly 4-191.095 Amended_____.*

**69O-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 | HMO COA Application Form | 12/05 ~~2/92~~ |
| ~~(b) OIR-943~~ | ~~Quarterly Report of Subscriber Grievances (Summary)~~ | ~~11/91~~ |
| ~~(c) OIR-944~~ | ~~Individual Quarterly Grievance Report~~ | ~~11/91~~ |
| ~~(d) OIR-945~~ | ~~Request for Review by the Statewide Subscriber Assistance Panel~~ | ~~11/91~~ |
| ~~(e) OIR-946~~ | ~~HMO Response Form for Statewide Subscriber Assistance Panel~~ | ~~11/91~~ |
| ~~(f) OIR-947~~ | ~~Annual HMO Report Form~~ | ~~11/91~~ |
| ~~(g) OIR-948~~ | ~~Annual Report Supplement – Audited Financial Statement~~ | ~~11/91~~ |
| (b ~~h~~) OIR-A2-949 | Annual Report Supplement – Contracts Issued & Outstanding | 07/04 ~~11/91~~ |
| (c ~~i~~) OIR-A2-950 | Annual Report Supplement – Damage Claims & Medical Injury | 07/04 ~~11/91~~ |
| ~~(j) OIR-951~~ | ~~Annual Report Supplement – Actuarial Certification~~ | ~~11/91~~ |
| ~~(k) OIR-952~~ | ~~Annual Report Supplement – Actuarial Report~~ | ~~11/91~~ |
| ~~(l) OIR-953~~ | ~~Quarterly HMO Report Form~~ | ~~11/91~~ |
| (d ~~m~~) OIR-C1-448 | Acquisition Application | 12/05 ~~5/89~~ |
| (e ~~n~~) OIR-C1-938~~954~~ | Fingerprint Card Instructions | 5/13 ~~4/91~~ |
| (f ~~o~~) OIR-C1-903 | Fingerprint Invoice | 12/05 ~~9/91~~ |
| (g ~~p~~) OIR-C1-144 | Consent and Agreement in Re: Service of Process | 06/04 ~~11/90~~ |
| ~~(q) OIR-414~~ | ~~Registration of Non-Office Representative~~ | ~~6/89~~ |
| (h ~~r~~)OIR-C1-1423 ~~422~~ | BiographicalAffidavit ~~Statement~~ | 8/14 ~~11/90~~ |
| ~~(s) OIR-449~~ | ~~Abbreviated Biographical~~ | ~~1/91~~ |
| (i ~~t~~) OIR-C1-450 | Authority for Release of Information | 5/00 ~~8/91~~ |
| (j) OIR-D0-516 | Insurance Holding Company System Annual Registration Statement | 5/16 |

(2) Form OIR-B2-1507, Form OIR-B2-1507A, and Form OIR-B2-1356 as incorporated in Rule 69O-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 ~~through~~ the Office of Insurance Regulation's web site: http://www.floir.com/iportal. ~~Bureau of Specialty Insurers, Tallahassee, Florida 32399-0300.~~

*Rulemaking ~~Specific~~ Authority 624.308(1), 641.36 FS. Law Implemented 624.424, 627.410(6), (7), 627.413(4), 627.4145, 627.6699(12)(d)4., 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 4-191.107Amended_____.*

**69O-192.058 Forms Incorporated by Reference.**

The following forms are incorporated into this rule chapter by reference to implement the provisions of Sections 624.436 through 624.45, F.S.:

| Title | Form Number |
|---|---|
| (1) Application for Certificate of Authority as a Multiple Employer Welfare Arrangement | OIR-C1-983 (4/95)~~486 (10/93)~~ |
| (2) Application Cover letter | OIR-C1-983 (4/95)~~486 (10/93)~~ |
| (3) Application Instructions | OIR-C1-984 (11/04) ~~(10/93)~~ |
| (4) Application Checklist | OIR-C1-985 (11/04) ~~(10/93)~~ |
| (5) Invoice | OIR-C1-980 (10/93) |
| (6) Management Information | OIR-C1-844 (4/19) ~~(10/91)~~ |
| (7) Instructions for Furnishing Background Investigative Reports | OIR-C1-905 ~~939~~ (08/93) |
| (8) Annual Statement | OIR-487 (4/89) |
| (9) Statement of Net Assets | OIR-488 (5/89) |
| (10) Statement of Change in Net Assets | OIR-489 (5/89) |
| (11) Authority to Release Information | OIR-C1-450 (5/00) ~~(8/91)~~ |
| (12) Biographical Statement and Affidavit | OIR-C1-422 (10/26/98)~~(11/90)~~ |
| (13) Statement of Acquisition Merger or Consolidation of a Specialty Insurer | OIR-C1-448 (12/91) |
| (14) Fingerprint Card Instructions | OIR-C1-938 |

(5/2013)

These forms shall become effective on the date this rule becomes effective. Copies of forms may be obtained from the Office of Insurance Regulation's web site: http://www.floir.com/iportal. ~~Application forms may be obtained from the Application Coordinator, Insurer Services Support, Tallahassee, FL 32399-0327. Copies of all other forms may be obtained from the Office of Insusrance Regulation, Bureau of Life and Health Insurer Solvency and Market Conduct, Larson Building, Tallahassee, FL 32399-0300.~~

*Rulemaking* ~~*Specific*~~ *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*_____.

**69O-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, Florida Statutes:

| | Title | Form Number |
|---|---|---|
| (1) | Application for Prepaid Health Clinic Certificate of Authority | OIR-C1-483(12/05) ~~(5/89)~~ |
| (2) | Annual Report | OIR-A2-949(07/04) and OIR-A2-950(07/04)~~482(1/90)~~ |
| (3) | Authority to Release Information | OIR-C1-450(5/00) ~~(8/89)~~ |
| (4) | Biographical Statement and Affidavit | OIR-C1-1423~~422~~(8/14)~~(8/89)~~ |
| (5) | Abbreviated Biographical Statement | OIR-449(5/89) |
| (6) | Consent and Agreement in re Service of Process | OIR-C1-144(06/2004)~~(1/90)~~ |
| (7) | Statement of Acquisition | OIR-C1-448(12/05)~~(5/89)~~ |
| (8) | Fingerprint Card Instructions | OIR-C1-938(5/2013) |
| (9) | Instructions for Investigative Report | OIR-C1-905(2/15) |

These forms shall become effective on the date this rule becomes effective. Copies of the forms may be obtained from the Office~~r~~ of Insurance Regulation's web site: http://www.floir.com/iportal., ~~Bureau of Specialty Insurers, Larson Building, Tallahassee, FL 32399-0300.~~

*Rulemaking ~~Specific~~ 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* _____.

**69O-202.008 General Eligibility Requirements.**

(1) Any person engaging in the business of issuing donor annuity agreements must notify the Office in writing in a form prescribed by the Office in Form OIR-C1-1208,Revised XX-17. Notification to the Florida Office of Insurance Regulation as a Qualifying Issuer of Donor Annuity Agreements Pursuant to Section 627.481, Florida Statutes, adopted in paragraph 69O-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, Florida Statutes, that fails to submit the required notification form is subject to penalty as provided in Section 626.9521, Florida Statutes.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 624.307(1), 627.481 FS. History–New 6-23-92, Amended 1-7-97, 12-24-03, Formerly 4-202.008 Amended_____.*

**69O-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,revised XX-17, adopted in paragraph 69O-202.015(1)(c), F.A.C., attesting that the issuer has met all requirements of law.

(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 ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 624.307, 624.307(1), 627.481 FS. History–New 6-23-92, Amended 1-7-97, 12-24-03, Formerly 4-202.012 Amended_____.*

**69O-202.015 Forms Incorporated by Reference.**

(1) The following forms are incorporated by reference to implement the provisions of Section 627.481, Florida Statutes:

| Title | Form Number |
|---|---|
| (a) Notification to the Florida Office of Insurance Regulation as a Qualifying Issuer of Donor Annuity Agreements Pursuant to Section 627.481, Florida Statutes | OIR-C1-1208 (rev. XX-17 ~~07/03~~) |
| (b) Sworn Statement in Lieu of Annual Statements For Issuers of Donor Annuity Agreements | OIR-A3-1209 (rev.XX-17 ~~07/03~~) |

(2) Copies of the forms may be obtained from the Office of Insurance Regulation's website at http://www.floir.com/iportal. ~~Bureau of Specialty Insurers, Larson Building, Tallahassee, FL 32399-0331, or on the Department of Financial Services website at www.fldfs.com.~~

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 624.307(1), 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_____.*

**69O-203.042 Filing, Approval of Subscriber Contract and Related Forms.**

(1) Every group or individual subscriber contract and every rider, endorsement, certificate, application, or other form to be used or issued in connection with any subscriber contract shall be filed by the PLHSO for approval by the Office before it may be delivered in this state, pursuant to the criteria in Section 636.018, F.S.

(2) Every form required to be filed by the PLHSO shall be identified by a unique form number, placed in the lower left hand corner of each form.

(3) Filing Format for All Forms. PLHSOs in possession of a Certificate of Authority shall submit contract filings to the Office electronically through http://www.floir.com/iportal. ~~mail contract filings to: Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, Post Office Box 8040, Tallahassee, Florida 32301-8040; submit filings electronically to https://Iportal.fldoi.com; or submit filings to the Office by Federal Express or any other form of special delivery by delivery to: Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328.~~ A filing shall consist of one copy of each of the following items:

(a) A brief letter explaining the type and nature of the filing. The letter shall indicate if the filing is for a new product, or a resubmission. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted, the Florida filing number, and the date of the disapproval.

(b) Form OIR-B2-1507, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter" as adopted in Rule 69O-149.022, F.A.C., completely filled out in accordance with Form OIR-B2-1507A, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet," as adopted by Rule 69O-149.022, F.A.C.

(c) The form being submitted by the PLHSO for approval.

(d) An actuarial memorandum consistent with the requirements of Rule 69O-203.045, F.A.C.

(e) Rate pages that define all proposed rates, rating factors, and methodologies for determining rates applicable in the state.

~~(4) Subsequent to July 1, 2003, all filings shall be submitted electronically to https://iportal.fldfs.com, or by computer diskette meeting the compatibility requirements mandated by Section 624.424(1)(c), F.S. Deadlines for filing will not be extended due to shipping delays, format incompatibility, data corruption, or any other impediment which results from an election to file by diskette.~~

*~~Rulemaking Specific~~ Authority 636.067 FS. Law Implemented 624.424, 636.016, 636.017, 636.018 FS. History–New 11-15-94, Amended 9-23-02, 6-19-03, Formerly 4-203.042 Amended_____.*

**69O-203.045 Rates.**

(1) Before charging premiums to subscribers, a PLHSO shall file the rating methodology by which those premiums were determined with the Office. The Office must approve the methodologies and premium rates before use. Filings of rating methodologies shall provide adequate information, so that the Office, in accordance with generally accepted actuarial principles as applied to Prepaid Limited Health Service Organizations, may verify that the rating methodology does not produce inadequate, excessive, or unfairly discriminatory premiums. The Office will consider the limited services provided, the method in which services are provided, and the method of provider payment to determine whether a rate is in compliance.

(2) All rate classifications should be clearly identified, and the formulas and/or methods of calculating premiums adequately described.

(3) An actuarial memorandum shall be provided for each new product filing, rate revision or justification of existing rates. The pricing assumptions shall reflect organizational experience to the degree credible and industry experience where organizational experience is not credible, available or appropriate. All such items shall be actuarially justified by supporting data. In reviewing these assumptions, the department will use, as an initial point of reference, comparisons of the assumptions with those from similar products of the same organization, similar products of other organizations and independent studies. The memorandum must contain the following items:

(a) Morbidity. This section shall describe the morbidity basis for the plan, including the source or sources used. The relationship between the morbidity assumptions and the benefits provided by the contract must be clearly demonstrated.

(b) Expenses. This section shall include a description of any expense assumptions used, including, but not limited to, per policy and percentage of premium expenses for acquisition, maintenance, commissions and state premium taxes.

(c) Contingency and Risk Margins. This section shall describe the margins anticipated for the contract at the time of the filing.

(4) To determine whether premium rates are excessive, the Office shall consider all items presented in the actuarial memorandum. In addition, significant attention shall be paid to the results provided in the organization's financial reports made with the Office.

(5) Rates are inadequate if the anticipated or actual revenues derived from the rating structure plus investment income are not at least equal to the anticipated or actual costs of benefits provided during the period for which the rates are to be effective plus the contract's expenses. For this analysis, investment income shall not exceed 3% of total projected revenues.

(6) Premiums are unfairly discriminatory if the benefit or expense portion of the premium is inadequate or excessive for any subgroup of risks.

(7) Rate filings shall be signed by a qualified actuary, who shall be a member of either the Society of Actuaries or the American Academy of Actuaries, and who is experienced in the development of rating methodologies for PLHSOs, or a qualified employee. Such rate filings shall include a certification that:

(a) The rates are neither inadequate nor excessive nor unfairly discriminatory;

(b) The rates are appropriate for the classes of risks for which they have been computed.

(8) Filing Format for All Rate Filings. A filing shall consist of one copy of each of the following:

(a) A brief letter explaining the type and nature of the filing. The letter shall indicate if the filing is for a new product, a rate revision, or a resubmission. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted, the Florida filing number, and the date of the disapproval.

(b) Form OIR-1507, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter," completely filled out in accordance with Form OIR-1507A, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet" as adopted by Rule 69O-149.022, F.A.C.

(c) An actuarial memorandum, consistent with the requirements of Rule 69O-203.045, F.A.C.

(d) Rate pages that define all proposed rates, rating factors, and methodologies for determining rates applicable in the state.

(9) Filings shall be submitted electronically to http://www.floir.com/iportal. ~~mailed to: Office of Insurance Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, Post Office Box 8040, Tallahassee, FL 32301-8040; submitted electronically to https://iportal.fldfs.com; or submitted to the Office by Federal Express or any other form of special delivery by delivery to: Office of Insurance Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328.~~

*Rulemaking ~~Specific~~ Authority 636.067 FS. Law Implemented 624.424, 636.017, 636.018, 636.043 FS. History–New 11-15-94, Amended 9-23-02, Formerly 4-203.045 Amended_____.*

**69O-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 (12/05) ~~(8/94)~~ |
| (2) Invoice – Request for Payment of Application Fees | OIR-C1-1119~~20~~ (12/05) ~~(7/93)~~ |
| (3) Invoice – Request for Payment of Fingerprint Charges | OIR-C1-903 (12/05) ~~(1/94)~~ |
| ~~(4) Biographical Statement and Affidavit~~ | ~~OIR-C1-1423422 (8/11) (11/90)~~ |
| ~~(5) Abbreviated Biographical Statement~~ | ~~OIR-449 (5/89)~~ |
| (5~~6~~) Authority for Release of Information | OIR-C1-450 (5/00)~~(8/91)~~ |
| (6~~7~~) Consent and Agreement; Service of Process | OIR-C1-144 (06/04)~~(11/90)~~ |
| (7~~8~~) Instructions for Furnishing Background Investigative Reports | OIR-C1-905 (2/15)~~(8/93)~~ |
| (8~~9~~) Fingerprint Card Instructions | OIR-C1-938 (5/13)~~(4/91)~~ |
| (9~~10~~) Acquisition Application | OIR-C1-448 (12/05)~~(5/89)~~ |
| ~~(11) Annual Report~~ | ~~OIR-1131 (1/94)~~ |
| ~~(12) Annual Report Supplement~~ | ~~OIR-1132 (1/94)~~ |
| ~~(13) Quarterly Report~~ | ~~OIR-1136 (1/94)~~ |
| (10) Annual Report Supplement - Contracts Issued and Outstanding | OIR-A2-949 (07/04) |
| (11) Annual Report Supplement – Damage Claims & Medical Injury | OIR-A2-950 |

(07/04)

All of the above forms may be obtained from the Office of Insurance Regulation's web site: http://www.floir.com/iportal. ~~Application forms may be obtained from the Application Coordinator, Insurer Services Support, Tallahassee, FL 32399-0327. All other forms may be obtained from the Office of Insurance Regulation, Bureau of Life and Health Insurer Solvency, Larson Building, Tallahassee, FL 32399-0327.~~

*Rulemaking ~~Specific~~ Authority 636.067 FS. Law Implemented 624.424, 624.321(1)(a), 636.005, 636.008, 636.009, 636.012, 636.043 FS. History–New 11-15-94, Formerly 4-203.100 Amended_____.*

69O-203.210 **Forms Incorporated by Reference.**

(1) The following forms are incorporated herein by reference to implement the provisions of Chapter 636, Part II, F.S.:

(a) The following forms which are hereby adopted:

| | FORM # | TITLE | DATE |
|---|---|---|---|
| 1. | OIR-C1-1606 | APPLICATION FOR LICENSE DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO) | 12/05 ~~10/14/04~~ |
| 2. | OIR-C1-1423 | BIOGRAPHICAL AFFIDAVIT | 8/20/14 ~~04/12/04~~ |

(b) The following forms as adopted in Chapter 69O-136, F.A.C.:

| | FORM # | TITLE | DATE |
|---|---|---|---|
| 1. | DI4-144 | SERVICE OF PROCESS CONSENT & AGREEMENT | 01/97 |
| 2. | OIR-C1-903 | INVOICE REQUEST FOR PAYMENT OF FINGERPRINT CHARGES | 12/05 ~~04/97~~ |
| 3. | OIR-C1-938 | FINGERPRINT CARD INSTRUCTIONS | 05/13~~02~~ |
| 4. | OIR-C1-1298 | MANAGEMENT INFORMATION FORM COMPLETE LIST OF OFFICERS, DIRECTORS, AND SHAREHOLDERS (10% OR MORE) | 10/05 ~~04/97~~ |

(c) OIR-A1-1671, Annual Report – Discount Medical Plan Organizations (06/08).

(2) All of the above referenced forms are available and may be printed from the Office~~'s~~ of Insurance Regulation's website: http://www.floir.com/iportal. ~~http://fldfs.com.~~

*Rulemaking ~~Specific~~ 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 Amended_____.*

# APPLICATION FOR CERTIFICATE OF AUTHORITY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

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 of Insurance Regulation. 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

Each of these sections is processed by different bureaus of the Office of Insurance Regulation. Therefore, it is extremely important that the application be completed in its entirety in the format specified.

Please submit your package tabularized 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).

THE COMPLETED CHECK LIST MUST BE RETURNED WITH THE APPLICATION PACKAGE!

It is recommended that, prior to filing the application, you schedule a pre-filing conference with the Bureau of Life and Health Solvency to go over particular problems 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 of Insurance Regulation. To schedule a conference, please call the Applications Coordination Section at (850) 413-2570.

Once the application is complete, mail it to:

Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street
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.**

DEPARTMENT OF FINANCIAL SERVICES
*Office of Insurance Regulation*

# APPLICATION FOR CERTIFICATE OF AUTHORITY
# HEALTH MAINTENANCE ORGANIZATION

The Health Maintenance Organization's Application for Certificate of Authority requires 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 important to complete each section in the specified format without omitting any requested information.

Please submit the application in a binder that has been two-hole punched at the top. Place tabs at the bottom of the documents, e.g., Tab II-1 would contain the certified Articles of Incorporation and all amendments.

Submit the completed application package to:

Department of Financial Services
Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Room 131
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.**

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(7)(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(7)(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(7)(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(7)(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(7)(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 call the Applications Coordination Section, Office of Insurance Regulation, (850) 413-2570.

## INSTRUCTIONS
## SECTION I - APPLICATION FEES AND FORM

**Section I-11** **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

Place a photocopy of the invoice and the check in this section.

**Section I-2** **Fingerprint Processing Fees**

A fee is charged for processing the fingerprint cards. The fingerprint cards along with the fees are due at the time the application is filed.

Secure the check to the enclosed invoice and mail to:

Department of Financial Services
Bureau of Financial t Services
PO Box 6100
Tallahassee, Florida 32301-0315

Place a photocopy of the invoice and the check in this section.

## Section I-3 Deposits and Assessments

A. Submit a check for $10,000 made payable to " Director 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

Place a photocopy of the invoice and the check in this section.

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:

Mr. James J. Bracher
J. Bracher & Associates
P. O. Box 16459
Tallahassee, FL 32317-6459
850-893-6686

Place a photocopy of your transmittal letter to the Plan Manager and the check in this section.

## 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.

## 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.

## 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 endorsed on the agreement as an additional insured.

**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.

## 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 HMOs 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.

**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.

## 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.

## 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.

## 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 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 Statement and Affidavits for Officers, Directors and Stockholders

The enclosed Biographical Statement and Affidavit must be completed for each officer, director and stockholder. All questions must be answered. Each form must contain an original signature and an original notary seal. Please file an original of each form.

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-3** **An Authority for Release of Information**

The enclosed Authority for Release of Information must be completed for each person listed in Section IV-1. Each form must contain an original signature and an original notary seal. Please file an original of each form.

**Section IV-4** **Investigative Background Reports**

An Investigative Background Report must be provided for each person listed in Section IV-1. These reports must be mailed directly to the Office from the reporting entity. Please arrange for the billing to be sent by the investigative reporting firm to your accounting office for payment. Please contact that investigating company for instructions.

Please provide evidence indicating that the reports have been ordered for all officers, directors, and stockholders. Evidence may include 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. It is recommended that the company order the investigative reports in advance (four weeks recommended) of filing the application with the Office in order to expedite the application.

**Section IV-5** **Fingerprint cards must be completed for each person listed in Section IV-1.**

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. Instructions for completing the fingerprint cards are included.

## 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: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 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 Processing Fees ..... | ☐ |
| | (a) | Copy of invoice included ..... | ☐ |
| | (b) | Copy of check included ..... | ☐ |
| | (c) | Check mailed to address on Invoice ..... | ☐ |
| 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 ..... | ☐ |

| Item # | | Completion Check List |
|---|---|---|
| (c) | Signed by President and other authorized officer (original signature) ..... | ☐ |
| (d) | Notarized ..... | ☐ |

## SECTION II - LEGAL

| Item # | | Completion Check List |
|---|---|---|
| 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 ..... | ☐ |

## SECTION III - FINANCIAL AND RELATED INFORMATION

| Item # | | Completion Check List |
|---|---|---|
| 1. | Insurance | ☐ |
| | (a) Copy of current general liability policy or plan for self-insurance<br>and<br>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 | ☐ |

| Item # | | | Completion Check List |
|---|---|---|---|
| | (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 ..... | ☐ |

| Item # | | Completion Check List |
|---|---|---|
| 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 ..... | ☐ |

## SECTION IV - MANAGEMENT

| Item # | | Completion Check List |
|---|---|---|
| 1. | Listing of all officers, directors, and stockholders, etc. ..... | ☐ |
| | (a) Separate listing of all officers and directors for the corporation (Official Form) ..... | ☐ |
| | (b) Separate listing of stockholders, including percentage held and number and class of shares (Official Form) ..... | ☐ |
| | (c) Chart of parent company ..... | ☐ |
| 2. | Biographical Statement and Affidavits as requested in Section IV-1 A and B (Official Form) ..... | ☐ |
| | For each biographical affidavit: | |
| | (a) All blanks completed ..... | ☐ |
| | (b) "Yes" answers explained ..... | ☐ |
| | (c) Contains original signature ..... | ☐ |
| | (d) Notarized (original) ..... | ☐ |
| | (e) Original of each affidavit submitted ..... | ☐ |

| Item # | | Completion Check List |
|---|---|---|
| 3. | Authority for Release of Information Forms for each individual requested in Section IV-1 A and B (Official Form) ..... | ☐ |
| | (a) Release form contains original signature ..... | ☐ |
| | (b) Each release form is Notarized (original) ..... | ☐ |
| | (c) Original of each release form submitted ..... | ☐ |
| 4. | Investigative Background Report for each individual requested in Section IV-1 A and B ..... | ☐ |
| | (a) Evidence indicating report has been ordered for all officers, directors and stockholders dated within 4 weeks prior to date of application (cancelled check or letter of transmittal) ..... | ☐ |
| | (b) Arrangements made for reports to be sent directly to this Office ..... | ☐ |
| 5. | Fingerprint cards enclosed for each person listed Section IV-1 A and B ..... | ☐ |
| | (a) Contains original signature ..... | ☐ |
| | (b) Card furnished by the Office ..... | ☐ |
| | (c) All information completed (DOB, SSN, Citizenship, Vital Statistics) ..... | ☐ |

## SECTION V - FORMS AND RATES

| Item # | | Completion Check List |
|---|---|---|
| 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 ..... | ☐ |

**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.

Signed this _____ day of _____, 20 ___

_____
President or other authorized officer (please print)

_____
Signature (Corporate Seal)

_____
Second authorized officer (please print)

_____
Signature

State of _____

County of _____

Sworn to and subscribed before me

this _____ day of _____, 20 ___

Notary Public

(Notary Seal)

My Commission Expires

**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 contact.

**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 |

Sworn to and Subscribed before me this_____day of_____, 20___.

_____ [SEAL]

Notary Public

# SERVICE OF PROCESS CONSENT & AGREEMENT

**(Please type or print all information clearly)**

*O Original Designation* *O Insurer Name Change* *O Merger I Acquisition* *O Update Delivery Information*

***Insurer or Company Name:***_____

*Previous Name (If applicable):* _____
*Home Office Address:* _____
*City, State, Zip* _____

_____ _____ _____
*FE/#* *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 poHcy, 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 resofution otthe Board of Directors or Governing body of said company delegating the authority to sign for the company.***

*69O-191.107*
*OIR-Cl-144*
*Rev*
*06/2004 (1/90)*

***Service of Process Section***
*200 East Gaines Street• PO Box 6200 • Tallahassee, FL 32314-6200 •(850) 413-4200 • Fax (850) 922-2544*

# ANNUAL REPORT

**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** | _____ |

# STATE OF FLORIDA
# DEPARTMENT OF FINANCIAL SERVICES
# OFFICE OF INSURANCE REGULATION
# AUTHORITY FOR RELEASE OF INFORMATION

I,_____, presently resident at

_____ and am affiliated with or proposed to be affiliatedwith

_____ which is applying for licensure or a permit to organize

by the Office of Insurance Regulation.

I understand that the Office of Insurance Regulation will conduct an investigation of my background. In that regard, I hereby waive any right of confidentiality as to matters related to this inquiry.

I hereby give my permission and waive any provisions of law that forbids any court, police agency, employer, firm, or person, disclosing any knowledge of information related to this inquiry that they have concerning me which is requested by the Office of Insurance Regulation. I further consent and request that the Director of the Office of Insurance Regulation, or his representative, be provided with a certified copy of any such record concerning me which they may deem necessary in the performance of their investigation.

I recognize that the Office of Insurance Regulation is subject to Chapter 119, F.S. and Section 626.989(5), F.S. with respect to confidential sources.

_____ _____

Applicant's Signature Date

This document was executed and signed in the presence of the following witnesses:

1._____ 2. _____

State of _____

County of _____

Sworn to and subscribed before me this _____ day of _____,20_____

_____

Notary Public

(Notary Seal)

My Commission Expires:

69O-191.107

**OIR-C1-450**
**REV(5/00)**
**~~(8/89)~~**

# PREPAID HEALTH CLINIC
# APPLICATION FOR CERTIFICATE OF AUTHORITY

MAIL TO: DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATIONS COORDINATION SECTION
TALLAHASSEE, FLORIDA 32399-0332.

## 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): _____

Two complete copies of the application must be submitted. Please be specific in your answers and provide supporting documentation for each item. The items are as follows:

## ORGANIZATIONAL

| | | |
|---|---|---|
| ____ 1. | S. 641.405(2)(f) | Enclose a copy of the Health Care Provider Certificate, as issued by the Department of Health and Rehabilitative Services 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. |

### Authority

| | | |
|---|---|---|
| ____ 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. 641405(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. Submit an original and one copy of biographical affidavits & Authority for Release of Information Forms.<br><br>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 or 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.

| | | |
|---|---|---|
| ____ 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. |

| | Authority | |
|---|---|---|
| | | **CONTRACTUAL** |
| ____ 11. | S. 641.405(2)(e) | Three copies 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. |

| | Authority | |
|---|---|---|
| | | **FINANCIAL** |
| ____ 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)<br>S. 641.409(1)(b)<br>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 an amount acceptable to the Office, which shall cover the subscribers in the event of |

insolvency of the PHC.

**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 _____.

_____ _____

_____ _____

_____ _____

Sworn to and subscribed before me this ____ day of _____, 20 ____

(SEAL) _____

_____
Notary Public

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, FLORIDA STATUTES (FS)

***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.

## NOTIFICATION TO THE OFFICE OF INSURANCE REGULATION AS A QUALIFYING ISSUER OF DONOR ANNUITY AGREEMENTS PURSUANT TO SECTION 627.481, FS

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: _____ , DATED: _____
(signed)

BY: _____ , DATED: _____
(signed)

**(CORPORATE SEAL)**

**Office of Insurance Regulation**
***Company Admissions***

# FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

## LiveScan (available to Florida Residents):

Applicants must pay online for processing of electronic fingerprints and make appointment for electronic fingerprinting. To begin the process, access MorphoTrustUSA

- Select English or Spanish to continue
- Enter First Name and Last Name
- Select "Continue"
- Enter Zip Code to determine closest fingerprint location or Choose "Region" and select "Go"
- Schedule Appointment
- Enter Applicant Information and select "Send Information"
- Verify and Select "Go"
- Select "Method of Payment" and "Send Payment Information"
- Select "Continue to US Bank E-Pay"
- Retain copy of payment confirmation

## Paper Card* (available to Florida Residents and Non-Residents):

Applicants must pay online for processing fingerprint cards. To begin the process, access MorphoTrustUSA

- Select English or Spanish to continue
- Enter First Name and Last Name and select "Go"
- Select "Non-Resident Card Submission" (Non-Residents and Florida Residents not utilizing LiveScan)
- Select "No Cards"
- Enter Applicant Information and select "Send Information". If Applicant does not have a Social Security Number, enter "123-12-1234" in the required SSN field
- Verify and Select "Go"
- Select "Method of Payment" and "Send Payment Information"
- Select "Continue to US Bank E-Pay"
- Retain copy of payment confirmation
- Mail completed cards with a cover letter to: Florida Office of Insurance Regulation
  Company Admissions
  200 East Gaines Street
  Tallahassee, Florida 32399-0332

Applicants may contact MorphoTrust USA's toll free registration center at 1-800-528-1358 regarding payment and/or appointment issues.

*Applicants must use fingerprint cards provided by the Office. Applicants must provide **two** completed cards per person. Blank fingerprint cards may be requested by emailing appcoord@floir.com or calling 850-413-2575.

Payment confirmations will be a required component in the electronic application submitted via iApply.

Questions may be emailed to appcoord@floir.com.

# CONFIDENTIAL

Pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07, 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 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. 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 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

# APPLICATION FOR CERTIFICATE OF AUTHORITY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

## CHECK LIST
## SECTION I - APPLICATION FEES AND FORM

Company Name: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 1. | | Specialty insurer application fees paid | ❑ |
| | (a) | Copy of invoice included (Official Form) | ❑ |
| | (b) | Copy of check | ❑ |
| | (c) | Originals mailed to Bureau of Financial and Support Services | ❑ |
| 2. | | Association completed application for license (Official Form) | ❑ |
| | (a) | All blanks completed | ❑ |
| | (b) | Sealed by association | ❑ |
| | (c) | Signed by President (original signature) | ❑ |

## APPLICATION FOR CERTIFICATE OF AUTHORITY
## MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

### SECTION II - LEGAL

Company Name: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 1. | | Articles of Incorporation of the Sponsoring Association ..... | ❑ |
| | (a) | Original certification by Florida Secretary of State..... | ❑ |
| | (b) | Articles with all amendments attached ..... | ❑ |
| 2. | | Certificate of Status from Florida Secretary of State of the Sponsoring Association ..... | ❑ |
| | (a) | Good standing indicated ..... | ❑ |
| | (b) | Sealed by state ..... | ❑ |
| | (c) | Signed by proper public official..... | ❑ |
| | (d) | Original and one copy..... | ❑ |
| 3. | | Association By-Laws, Rules and Regulations, and/or Constitution ..... | ❑ |
| | (a) | Signed and dated by association secretary..... | ❑ |
| | (b) | Sealed by association..... | ❑ |
| | (c) | Original and one copy..... | ❑ |
| 4. | | Trust Agreement..... | ❑ |
| | (a) | Agreement signed by all trustees (Original and one copy) ..... | ❑ |
| | (b) | Other documents specifying authority of trustees (Original and one copy) ..... | ❑ |

5. Articles of Incorporation of the Arrangement ..... ❑

   (a) Original and one copy ..... ❑

6. Bylaws of the Arrangement ..... ❑

   (a) Original and one copy ..... ❑

7. Certificate of Status of the Arrangement ..... ❑

   (a) Original and one copy ..... ❑

## APPLICATION FOR CERTIFICATE OF AUTHORITY
## MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

## SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 1. | Federal form 5500 | | ❑ |
| 2. | Plan of Operations | | ❑ |
| | (a) | Current operations | ❑ |
| | | 1. Number of employers | ❑ |
| | | 2. Number of employees | ❑ |
| | | 3. Number of dependents | ❑ |
| | (b) | Management | ❑ |
| | | 1. Relationship identified between arrangement's trustees and their employers | ❑ |
| | | 2. Officers' employers names and addresses | ❑ |
| | | 3. List of individuals responsible for managing funds of arrangement | ❑ |
| | (c) | Administration | ❑ |
| | | 1. TPA License attached | ❑ |
| | | 2. TPA Agreement attached | ❑ |
| | (d) | Claims adjusting and underwriting | ❑ |
| | | 1. Number of adjusters and underwriters | ❑ |
| | | 2. Plan to service billings, claims, and underwriting | ❑ |
| | | 3. Justification of underwriting criteria | ❑ |

4. Special health test procedures ..... ❑

(e) Marketing and growth ..... ❑

1. Marketing efforts ..... ❑

2. List of persons employed to solicit participants or adjust claims ❑

3. Type of licenses or qualifications ..... ❑

4. List of individuals contracted to solicit ..... ❑

3. Fidelity bond ..... ❑

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 requirement ..... ❑

## APPLICATION FOR CERTIFICATION OF AUTHORITY
## MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

### SECTION IV - MANAGEMENT

Company Name: _____

| Item # | | Completion Check List |
|---|---|---|
| 1. | Alphabetical listing of officers, directors, and trustees | ❑ |
| | (a) Separate listing of all officers and directors for sponsoring association (Official Form) | ❑ |
| | (b) Separate listing of trustees (Official Form) | ❑ |
| | (c) Full names listed | ❑ |
| | (d) Titles listed | ❑ |
| 2. | Biographical affidavits for each individual listed in Section IV-1 (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 | ❑ |
| 3. | Authority for Release of Information forms for each individual listed in Section IV-1 (Official Form) | ❑ |
| | For each release form: | |
| | (a) Contains original signature | ❑ |
| | (b) Notarized (original) | ❑ |

(c) Submitted original of each release form ..... ❑

4. Investigative Background Report for each individual listed in Section IV-1 ❑

(a) Investigative reporting firm contacted ..... ❑

(b) Full names given to investigative reporting firm for all individuals listed in Section IV-1 ..... ❑

(c) Arrangements made for reports to be sent directly to this Office ..... ❑

(d) Evidence indicating background investigative 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) ..... ❑

## APPLICATION FOR CERTIFICATE OF AUTHORITY
## MULTIPLE EMPLOYER WELFARE ARRANGEMENT

## SECTION V - FORMS AND RATES

Company Name: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 1. | Forms | | ❑ |
| | (a) | 3 copies | ❑ |
| | (b) | Contain assessability language | ❑ |
| | (c) | Meet flesch score requirements | ❑ |
| 2. | Marketing material | | ❑ |
| | (a) | Advertising material | ❑ |
| | (b) | Participating employer application | ❑ |
| | (c) | Description of association support | ❑ |
| 3. | Rates to be charged | | ❑ |
| | (a) | 3 copies | ❑ |
| 4. | Actuarial report | | ❑ |
| | (a) | Prepared by certified actuary | ❑ |
| | (b) | Prepared in accordance with standards of 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 ARRANGEMENTS

## INSTRUCTIONS
## SECTION I - APPLICATION FEES AND FORM

### Section I-1 Application Fees

Applicants must pay a filing fee of $1,500.00, pursuant to Section 624.501(1)(a), Florida Statutes. 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 mail 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 Application for Certificate of Authority (Official Form)

The sponsoring association should complete this form and have it signed by the President. Original signatures and association seal (if any) are required on the application form submitted to the Office of Insurance Regulation.



OIR-C1-984
(11/04) (~~10/93~~)
69O-192.058

## SECTION II - LEGAL

**Section II-1** **Articles of Incorporation of Sponsoring Association**

Include in this section, the applicant's Articles of Incorporation and all amendments, if applicable. They must be certified by the applicant's state of domicile, by the public official with whom the originals are on file in the state of domicile. The certification must be an original and obtained from that 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 of Sponsoring Association**

A Certificate of Status is a document issued by the Florida Secretary of State. This document shows that the association is duly organized and that all taxes and fees have been paid.

This certificate must be obtained from the Florida Secretary of State's office no earlier than six months prior to the date the application is filed. It must show good standing, be sealed by the state, and be an original (photocopies will not be acceptable). SUBMIT AN ORIGNAL AND ONE COPY.

**Section II-3** **By-Laws, Constitution, or Rules and Regulations of the Association**

The By-Laws, Constitution, and/or Rules and Regulations should be filed in this section. These documents must be signed and dated by the Secretary of the association. **NO** other signatures will be accepted other than the Secretary's signature. SUBMIT AN ORIGINAL AND ONE COPY.

**Section II-4** **Trust Agreement Establishing the Arrangement**

The Trust Agreement between the association and the arrangement (if applicable) should be included in this section. The Trust Agreement must be signed by all of the trustees.

If the trust agreement or bylaws do not specifically indicate that the trustees have complete fiscal control over and are responsible for all operations of the arrangement, that the trustees have authority to approve applications of association members for participation in the arrangement, and that the trustees have authority to contract with an authorized administrator or service company to administer the day-to-day affairs of the arrangement, attach other documents which specify their authority. SUBMIT AN ORIGINAL AND ONE COPY OF THIS DOCUMENT.

**Section II-5** **Articles of Incorporation of the Arrangement**

The Articles of Incorporation of the Arrangement and all amendments should be included in this section. Articles of Incorporation must bear an original certification from the applicant's state of domicile, by the public official with whom the originals are on file in the state of domicile. SUBMIT AN ORIGINAL AND ONE COPY OF THIS DOCUMENT.

**Section II-6** **By-Laws of the Arrangement**

The By-laws of the Arrangement should be included in this section. By-laws must bear an original corporate seal, be signed and dated by the secretary. SUBMIT AN ORIGINAL AND ONE COPY OF THIS DOCUMENT.

**Section II-7** **Certificate of Status of the Arrangement**

A Certificate of Status of the Arrangement should be provided in this section. This is a document issued by the Florida Secretary of State's Office showing that the arrangement is duly organized and that all taxes and fees have been paid.

This certificate must be 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 OF THIS DOCUMENT.

## APPLICATION FOR CERTIFICATE OF AUTHORITY
## MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

## SECTION III - FINANCIAL AND RELATED INFORMATION

### Section III-1 Financial Requirement

Existing arrangements should submit in this section a copy of IRS Federal Form 5500 entitled, Annual Return of Employer Benefit Plan With More Than One Hundred Participants.

### Section III-2 Plan of Operations

It is important for the Office of Insurance Regulation to have a clear understanding of the proposed operations of the arrangement and the goals it seeks to achieve. To fulfill this requirement, the plan of operations must consist of the following information:

A. **Current Operations.** Applicant should identify the number of employers currently participating in the arrangement. The number of participant units and number of dependents covered by the arrangement should also be indicated.

B. **Management.** Applicant should indicate if each trustee is either an owner, partner, officer, director, and/or employee of a participating employer or is committed to participate in the arrangement. In addition, the applicant should provide the name and address of the employer represented by each trustee and by each officer and provide the association of the trustee or officer with such employer.

Applicant should also list the individuals responsible for managing or handling funds or assets of the arrangement.

C. **Administration.** Applicant should give the name of the service company or third party administrator responsible for servicing the program of the arrangement and should attach a copy of the company's Florida license. In addition, 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.** Applicant should indicate that the arrangement has provided a sufficient number of competent persons to service its program in the areas of claims adjusting and underwriting. Applicant should also describe the present or proposed plan to service billings, claims, and underwriting. 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.** Applicant should provide an outline and description of the management's marketing efforts. Applicant should also list, in this section, the names of all persons directly employed by the arrangement, who solicit participants or adjust claims, indicating whether such person has a license issued by the Office of Insurance Regulation and if so, what type of license. For individuals without licenses, applicant should provide their qualifications.

In addition, applicant should list outside individuals contracted to solicit for the arrangement.

**Section III-3** **Fidelity Bond**

In this section, the applicant should 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 no less than 10% of funds handled annually, but in no case should it be less than $50,000 or more than $500,000.

**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. Along with it, submit a summary description of the agreement with enough detail to indicate the nature of the coverage.

**Section III-5** **Fund Balance**

Provide evidence that the arrangement has a fund balance equal to $200,000. Licensed MEWA's should submit a certified financial statement. This information for MEWA's being newly formed should be reflected in the projections of the feasibility study.

**Section III-6** **Feasibility Study**

Each applicant must submit a comprehensive feasibility study, performed by a certified public accountant in conjunction with a certified actuary (see Section V-4). The study should include a financial analysis, as well as enrollment assumptions and competitor information. The study should be for the greater of three years or until the arrangement has been projected to be profitable for twelve consecutive months. The study should show that the arrangement would have and maintain a fund balance as required by Section 624.4392, Florida Statutes and would not, at the end of any month of the

projection period, have less than the required balance per Section 624.4392, Florida Statutes. The feasibility study should contain an opinion by the CPA performing the study

which must 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 feasibility study must 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 and must contain nothing less than an "examination opinion". Outlined below are the requirements for the feasibility study:

A. A description of market potential, market penetration, and market competition.

B. A current audited financial statement prescribed by Section 624.439(11) 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 five years.

**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. A projected income statement on a monthly basis, with an annual total, through break even. The income statement should be for a minimum of three years and should be developed on a statutory accounting principle basis.

D. A projected cash flow analysis on a monthly basis, with an annual total through break even for a minimum of three 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.

E. A projected balance sheet annually through break even. The balance sheet should be for a minimum of three 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.

F. A statement of the proposed initial cash and cash reserves summary. This should be inclusive (loan receipts, loan repayments, stock sales, etc). Also, include a description of the source and terms of the funding.

G. The method in which the Multiple Employer Welfare Arrangement will comply with the insolvency protection deposit requirements of Section 624.441, F.S., 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 ARRANGEMENTS

### SECTION IV - MANAGEMENT

**ANY NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES.**

**Section IV-1 Alphabetical List of All Officers, Directors and Trustees (Official Forms Enclosed)**

A. A list of the name, address, and title of each officer (president, vice-president, secretary, treasurer, and chief financial officer) and director of the sponsoring association.

B. A list of the names and addresses of each trustee.

**Section IV-2 Biographical Affidavits for Officers, Directors and Trustees (Official Form Enclosed)**

A Biographical Affidavit **(Official Florida Form Only!)** must be completed for each officer, director, and trustee listed in Section IV-1, above. All questions must be answered and all "yes" answers must be accompanied by an explanation. Each Biographical Affidavit must contain an original signature of the principal and an original notary seal. SUBMIT AN ORIGINAL OF EACH BIORGAPHICAL AFFIDAVIT IN THE ORDER OF THE LIST FROM SECTION IV-1.

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-3** **Authority for Release of Information (Official Form Enclosed)**

An Authority for Release of Information form must be completed for each person listed in Section IV-1. Each Authority for Release form must contain an original signature of the principal and an original notary seal. SUBMIT AN ORIGINAL OF EACH AUTHORITY FOR RELEASE FORM IN THE ORDER OF THE LIST PROVIDED IN SECTION IV-1.

**Section IV-4** **Investigative Background Reports**

An investigative background report must be provided for each person listed in Section IV-1. These reports must be mailed directly to the Office of Insurance Regulation from a background investigative agency. As 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. See the enclosed form, Instructions For Furnishing Background Investigative Reports, in this package for ordering these reports.

Evidence indicating that these 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 V - FORMS AND RATES

**NOTE: THE COMPANY IS CAUTIONED NOT TO WRITE BUSINESS USING UNAPPROVED FORMS.**

### Section V-1 Forms

SUBMIT THREE COPIES of the policy, contract, certificate of coverage, summary plan description, and/or other evidence of the benefits and coverages provided to each covered employee. Such evidence of benefits and coverages must contain in bold-faced print of at least 12-point type in a conspicuous location, the following statements:

> "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."

The form(s) must also meet the Flesch score requirements of Section 627.4145, Florida Statutes.

### Section V-2 Marketing Material

In this section, provide advertising material, participating employer application, and a description of association support.

### Section V-3 Rates

SUBMIT THREE COPIES of the complete schedule of proposed premium rates for each type of contract.

### Section V-4 Actuarial Rate Analysis

In this section, the 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 and that proposed rates will provide sufficient revenues to pay current and future liabilities. The actuarial justification of rates should be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly.

The actuarial report should include a description of assumptions, an estimation of incurred but not reported claims (IBNR), and a forecast of rates and claims. It should also include an actuarial certification to the following:

A. The rates are neither inadequate nor excessive nor unfairly discriminatory.

B. The rates are appropriate for the classes or risks for which they have been computed.

C. An adequate description of the rating methodology has been provided and that such methodology follows consistent and equitable actuarial principles.

**NOTE: THE ANALYSIS MUST CONTAIN AN ACTUARIAL CERTIFICATION THAT THE ARRANGEMENT'S RATES WILL CONTRIBUTE TO THE ACTUARIAL SOUNDNESS OF THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT. IT MUST INCLUDE A DETAILED EXPLANATION OF HOW THE RATES WERE DERIVED.**

**Office of Insurance Regulation**

***Company Admissions***

## 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.

2. Please refer to the NAIC website at http://www.naic.org/documents/industry_ucaa_third_party.pdf, "Third Party Vendors for Background Reports", for specific information regarding background investigation vendors.

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 transmit investigative reports electronically to the Florida Office of Insurance Regulation ("Office") to this e-mail address: bkgrnd-inv@floir.com 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. Any questions regarding this process may be directed to the Office at appcoord@floir.com

DEPARTMENT OF FINANCIAL SERVICES
*Office of Insurance Regulation*

# APPLICATION FOR CERTIFICATE OF AUTHORITY
# HEALTH MAINTENANCE ORGANIZATION

The Health Maintenance Organization's Application for Certificate of Authority requires 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 important to complete each section in the specified format without omitting any requested information.

Please submit the application in a binder that has been two-hole punched at the top. Place tabs at the bottom of the documents, e.g., Tab II-1 would contain the certified Articles of Incorporation and all amendments.

Submit the completed application package to:

Department of Financial Services
Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Room 131
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.**

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(7)(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(7)(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(7)(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(7)(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(7)(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 call the Applications Coordination Section, Office of Insurance Regulation, (850) 413-2570.

## INSTRUCTIONS
## SECTION I - APPLICATION FEES AND FORM

### Section I-11 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

Place a photocopy of the invoice and the check in this section.

### Section I-2 Fingerprint Processing Fees

A fee is charged for processing the fingerprint cards. The fingerprint cards along with the fees are due at the time the application is filed.

Secure the check to the enclosed invoice and mail to:

Department of Financial Services
Bureau of Financial t Services
PO Box 6100
Tallahassee, Florida 32301-0315

Place a photocopy of the invoice and the check in this section.

## Section I-3 Deposits and Assessments

A. Submit a check for $10,000 made payable to " Director 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

Place a photocopy of the invoice and the check in this section.

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:

Mr. James J. Bracher
J. Bracher & Associates
P. O. Box 16459
Tallahassee, FL 32317-6459
850-893-6686

Place a photocopy of your transmittal letter to the Plan Manager and the check in this section.

## 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.

## 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.

## 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 endorsed on the agreement as an additional insured.

**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.

## 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 HMOs 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.

**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.

## 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.

## 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.

## 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 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 Statement and Affidavits for Officers, Directors and Stockholders

The enclosed Biographical Statement and Affidavit must be completed for each officer, director and stockholder. All questions must be answered. Each form must contain an original signature and an original notary seal. Please file an original of each form.

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-3 An Authority for Release of Information**

The enclosed Authority for Release of Information must be completed for each person listed in Section IV-1. Each form must contain an original signature and an original notary seal. Please file an original of each form.

**Section IV-4 Investigative Background Reports**

An Investigative Background Report must be provided for each person listed in Section IV-1. These reports must be mailed directly to the Office from the reporting entity. Please arrange for the billing to be sent by the investigative reporting firm to your accounting office for payment. Please contact that investigating company for instructions.

Please provide evidence indicating that the reports have been ordered for all officers, directors, and stockholders. Evidence may include 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. It is recommended that the company order the investigative reports in advance (four weeks recommended) of filing the application with the Office in order to expedite the application.

**Section IV-5 Fingerprint cards must be completed for each person listed in Section IV-1.**

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. Instructions for completing the fingerprint cards are included.

## 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.

## CHECK LIST
## SECTION I - APPLICATION FEES AND FORM

Company Name: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 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 Processing Fees ..... | ☐ |
| | (a) | Copy of invoice included ..... | ☐ |
| | (b) | Copy of check included ..... | ☐ |
| | (c) | Check mailed to address on Invoice ..... | ☐ |
| 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 ..... | ☐ |

| Item # | | Completion Check List |
|---|---|---|
| (c) | Signed by President and other authorized officer (original signature) ..... | ☐ |
| (d) | Notarized ..... | ☐ |

## SECTION II - LEGAL

| Item # | | Completion Check List |
|---|---|---|
| 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 ..... | ☐ |

## SECTION III - FINANCIAL AND RELATED INFORMATION

| Item # | | Completion Check List |
|---|---|---|
| 1. | Insurance | ☐ |
| | (a) Copy of current general liability policy or plan for self-insurance<br>and<br>Current medical malpractice policy or plan for self-insurance | ☐<br>☐ |
| | (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 | ☐ |

| Item # | | | Completion Check List |
|---|---|---|---|
| | (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 ..... | ☐ |

| Item # | | Completion Check List |
|---|---|---|
| 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 ..... | ☐ |

## SECTION IV - MANAGEMENT

| Item # | | | Completion Check List |
|---|---|---|---|
| 1. | Listing of all officers, directors, and stockholders, etc. ..... | | ☐ |
| | (a) | Separate listing of all officers and directors for the corporation (Official Form) ..... | ☐ |
| | (b) | Separate listing of stockholders, including percentage held and number and class of shares (Official Form) ..... | ☐ |
| | (c) | Chart of parent company ..... | ☐ |
| 2. | Biographical Statement and Affidavits as requested in Section IV-1 A and B (Official Form) ..... | | ☐ |
| | For each biographical affidavit: | | |
| | (a) | All blanks completed ..... | ☐ |
| | (b) | "Yes" answers explained ..... | ☐ |
| | (c) | Contains original signature ..... | ☐ |
| | (d) | Notarized (original) ..... | ☐ |
| | (e) | Original of each affidavit submitted ..... | ☐ |

| Item # | | Completion Check List |
|---|---|---|
| 3. | Authority for Release of Information Forms for each individual requested in Section IV-1 A and B (Official Form) ..... | ☐ |
| | (a) Release form contains original signature ..... | ☐ |
| | (b) Each release form is Notarized (original) ..... | ☐ |
| | (c) Original of each release form submitted ..... | ☐ |
| 4. | Investigative Background Report for each individual requested in Section IV-1 A and B ..... | ☐ |
| | (a) Evidence indicating report has been ordered for all officers, directors and stockholders dated within 4 weeks prior to date of application (cancelled check or letter of transmittal) ..... | ☐ |
| | (b) Arrangements made for reports to be sent directly to this Office ..... | ☐ |
| 5. | Fingerprint cards enclosed for each person listed Section IV-1 A and B ..... | ☐ |
| | (a) Contains original signature ..... | ☐ |
| | (b) Card furnished by the Office ..... | ☐ |
| | (c) All information completed (DOB, SSN, Citizenship, Vital Statistics) ..... | ☐ |

## SECTION V - FORMS AND RATES

| Item # | | | Completion Check List |
|---|---|---|---|
| 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 | ☐ |

**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.

Signed this _____ day of _____, 20 ____

_____
President or other authorized officer (please print)

_____ (Corporate Seal)
Signature

_____
Second authorized officer (please print)

_____
Signature

State of _____

County of _____

Sworn to and subscribed before me

this _____ day of _____, 20 ____

Notary Public

(Notary Seal)

My Commission Expires

**Department of Financial Services**
*Office of Insurance Regulation*

# STATEMENT OF ACQUISITION, MERGER OR CONSOLIDATION OF A SPECIALTY INSURER PURSUANT TO FLORIDA STATUTES 628.461, 628.4615

1. Acquiring Company:

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone Number)

_____
(Federal Identification Number)

_____
(Contact Person)

2. Specialty Insurer Affected: Certificate of Authority or License Number

_____

_____
(Type of Certificate of Authority)

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone Number) (Fax Number)

_____
(Federal Identification Number)

3. This filing is for (check those applicable):

   a) Acquisition of Controlling Stock (Corporation) ☐
   b) Acquisition of ownership interest (Partnership) ☐
   c) Acquisition of parent company ☐
   d) Merger or Consolidation ☐

4. Check one or both of the following:

   a) This filing affects a Specialty Insurer licensed with the Office pursuant to Chapter _____, Florida Statutes.

   b) This filing affects a company which controls a Specialty Insurer licensed with the Office pursuant to Chapter _____, Florida Statutes.

5. The transaction for which this form is filed is scheduled to Occur _____ or, if it is a post filing, occurred._____.

6. In summary, the transaction is as follows: _____

_____

_____

_____

_____

7. A statement of Acquisition, Consolidation or Merger was submitted to the Office on _____ (date submitted).

8. This statement was sent by registered mail on _____20_____ (date sent) to the Specialty Insurer and any controlling company, if applicable. Please note any additional information required by the Office pursuant to Section 628.4615(4), Florida Statutes, must also be sent by registered mail to the Specialty Insurer and to the controlling company of the Specialty Insurer.

   Provide documentation to support this information was received.

9. Have there been any material changes in the facts set forth in the Statement of Acquisition, Consolidation or Merger since it was filed by the Office?
___Yes ___No

If yes, include amendments which set forth the changes. If yes, when was the notice of these changes sent to the affected parties (listed in #8) by registered mail _____ (date sent)?

10. a) Does the acquiring person or persons plan to:

i) Liquidate the Specialty Insurer? ____ Yes ____ No

ii) Sell its assets? ____ Yes ____ No

iii) Merge or consolidate with any other person? ___ Yes ___ No

iv) Make any major change in its business or corporate structure or management? ____ Yes ____ No

(If the acquirer does intend to do one or more of the above, such plan must demonstrate that it is fair and free of prejudice to the insureds of the Specialty Insurer and to the public. The burden of proof is on the acquiring entity.)

b) Does the acquiring person plan to:

i) Liquidate the parent of the Specialty Insurer? ___ Yes ___ No

ii) Sell the assets of the parent of the Specialty Insurer?
____ Yes ____No

iii) Merge the parent or consolidate it with any other person?
____ Yes ____ No

iv) Make any major change in the parent's business or corporation structure or management? ____ Yes ____ No

(If the acquirer does intend to do one or more of the above, such plan must demonstrate that it is fair and free of prejudice to the insureds of the Specialty Insurer and to the public. The burden of proof is on the acquiring entity.)

11. Upon completion of the acquisition, will the Specialty Insurer be able to satisfy the requirement for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certified? ____ Yes ____ No

If "NO", explain.

12. If the acquisition has already taken place, has the acquirer agreed not to make any material changes in the management or operation of the Specialty Insurer or its controlling company while this application is being considered? ____ Yes ____ No

a) Has the acquirer agreed not to obligate 5% or more of its net worth? ____ Yes ____ No

b) Has the acquirer agreed not to make any managerial changes? ____ Yes ____ No

13. For HMOs only:

a) If for-profit, a statement setting forth method of compliance with Florida Statute 628.451.

b) If non-profit, a statement setting forth method of compliance with Florida Statute 628.471.

14. Identify the source and amount of the funds or other consideration used, or to be used, in making the acquisition.

## EXHIBITS

1. All written agreements between parties.

2. Summary of any verbal agreements between parties including:

a) Any transfer of securities?

b) Any option arrangements?

c) Any puts or calls?

d) Any proxies given or received?

3. Description of the transaction including:

   a) Controlling interest;

   b) Terms of the acquisition;

   c) Number and percentage of shares to be acquired;

   d) Any transfer of securities, any option arrangements, any calls, any proxies given or received.

4. Financial statements of the acquiring company which clearly indicate the acquiring company can fulfill its financial responsibilities.

5. Evidence that all required reserves are in place.

6. Copies of all new or revised escrows, contracts or agreements which demonstrate compliance with all applicable statutory provisions by the acquiring company.

7. Evidence that the status of revised and existing escrows, contracts or agreements with the consumer are, and will be, satisfactory.

8. If needed, copies of pro-forma financial statements which clearly demonstrate the effect of the acquisition after completion of the transaction.

9. A statement outlining material changes in the operation or business operations of the affected company or a statement citing no adverse material change in operations.

10. Certified copies of the appropriate organizational documents of the acquiring company, i.e., Articles of Incorporation, Bylaws, Partnership Agreements, Certificate of Good Standing, etc. and 1 facsimile copy of each.

11. Evidence that all requirements have been met with respect to:

    a) Bonding
    b) Deposits
    c) Reserves
    d) Solvency
    e) Insurance

12. Status of existing debts or obligations including all claims of the Specialty Insurer.

13. An organizational chart indicating the corporate structure of the acquiring entity and the seller, which reflects all affiliate entities prior to and subsequent to the acquisition for each.

14. Biographical Statements on Office forms for each natural person who possesses, directly or indirectly, the power to direct or cause the direction of the management or policies of the applicant, whether through the ownership of voting securities, title or position, by contract or otherwise; including all partners, and if a corporation, all stockholders and directors, and the President, Chief Executive Officer, all Vice-Presidents, Secretary, Treasurer and Chief Financial Officer.

15. "Waiver of Public Hearing and Request for Approval," Form.

16. If an HMO, file documents supporting compliance with Florida Statutes 628.451 or 628.471, as applicable.

17. Other (identify and explain):

**The Following Attestation Form Shall Be Used:**

I, the undersigned, do hereby affirm that all the responses, information, exhibits and documentary evidence submitted with and in support of this application are true and correct.

(Corporate Seal)

_____
(Typed Name and Title)

State of_____

_____
(Signature)

County of _____

Sworn to and subscribed before me

this _____ day of _____ , 20_____

_____
(Notary Public)

(Seal)

My Commission Expires _____

## WAIVER OF PUBLIC HEARING AND REQUEST FOR APPROVAL

We, the undersigned, on behalf of _____

hereby waive our right to a public hearing on the proposed acquisition of

_____ by _____

a _____ corporation, as outlined in the documents submitted pursuant to Florida Statutes S.628.4615, and respectfully request that the Director of the Office of Insurance Regulation approve the acquisition immediately.

Date: _____

Attest: _____ By _____
(Name and Title) (Name and Title)

_____ By _____
(Name and Title) (Name and Title)

**Department of Financial Services**

*Office of Insurance Regulation*

# 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.**

**69O-203.100**
**OIR-C1-1119**
**(12/05)(~~8/94~~)**

# 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.

## 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: _____

| Item # | | Completion Check List |
|---|---|---|
| 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: _____

| Item # | | Completion Check List |
|---|---|---|
| 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**

| Item # | | Completion Check List |
|---|---|---|
| 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: _____

| Item # | | | Completion Check List |
|---|---|---|---|
| 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.

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a prepaid limited health service 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.

Signed this _____ day of _____, 20___

_____
President or other authorized officer
(Please print)

_____
Signature (Corporate Seal)

State of _____

County of _____

Sworn to and subscribed before me this ____ day of _____20__

_____
Notary Public

(Notary Seal)

_____
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 |

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

# BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

**(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.

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:

| College/University | City/State | Dates Attended (MM/YY) | Degree Obtained |
|---|---|---|---|
| | | | |

| Graduate Studies | College/University | City/State | Dates Attended (MM/YY) | Degree Obtained |
|---|---|---|---|---|
| | | | | |

| Other Training: Name | City/State | Dates Attended (MM/YY) | Degree/Certification Obtained |
|---|---|---|---|
| | | | |

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 in the space provided in the Biographical Affidavit Supplemental Information.

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

6. List of memberships in professional societies and associations:

| Name of Society/Association | Contact Name | Address of Society/Association | Telephone Number of Society/Association |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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.

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: _____


2015 National Association of Insurance Commissioners

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 ☐

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, 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,

2015 National Association of Insurance Commissioners

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 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?

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 ☐

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

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.

_____
(Signature of Affiant)

State of:_____County of: _____

The foregoing instrument was acknowledged before me 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.

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 "NONE," SO STATE.

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.

| Beginning/Ending Date(s) Used (MM/YY) | Name(s) Specify: First, Middle or Last Name | Reason (If none, indicate such) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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.

3. Affiant's Social Security Number: _____

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

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

6. Date of Birth: (MM/DD/YY) :_____Place of Birth, City: _____
   State/Province:_____Country: _____

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

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

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

| Beginning/Ending Dates (MM/YY) | Address | City | State/ Province | Country | Postal Code |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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.

_____
(Signature of Affiant)

State of:_____County of: _____

The foregoing instrument was acknowledged before me 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


2015 National Association of Insurance Commissioners

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) twelve (12) 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 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

(8/14) ~~(8/89)~~
FORM 11

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) twelve (12) 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 this _____day of_____, 20_____by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name


©2015 National Association of Insurance Commissioners

Applicant Company Name : _____

NAIC No. _____
FEIN: _____

_____
My Commission Expires

Printed Notary Name

My Commission Expires
(8/14) ~~(8/89)~~
FORM 11

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 twelve (12) 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 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

**DEPARTMENT OF FINANCIAL SERVICES**
***Office of Insurance Regulation – Bureau of Life and Health Solvency***

# HEALTH MAINTENANCE ORGANIZATION

Annual Report Filing Fees

(as provided under Section 641.29, F.S.)

(Name of HMO)

| Filing Fee | Amount | Type | Class | Fund | Account | Source |
|---|---|---|---|---|---|---|
| Annual Fee | $150.00 | 12 | 48 3 | 09 | 1 | |

_____ ATTACH YOUR CHECK HERE

RETURN TO:
DEPARTMENT OF FINANCIAL SERVICES
BUREAU OF LIFE & HEALTH SOLVENCY
POST OFFICE BOX 6100
REVENUE PROCESSING SECTION
TALLAHASSEE, FL 32314-6100

69O-191.107
OIR-A2-1083
01/03

**Insurance Regulation**
*alth Financial Oversight*

## 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

This _____ day of _____, 20

Notary Public: _____

Commission Number: _____

Expiration Date: _____

_____
(Typed Name)

_____
(Signature)

_____
(Title)

Subscribed and sworn to before me

This _____ day of _____, 20____

Notary Public: _____

Commission Number: _____

Expiration Date: _____

# 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**

**69O-167.002 Private Passenger Motor Vehicle Insurance; Completion of Underwriting Notice of Incorrect Premium, Return of Unearned Premium.**

(1) Pursuant to the provisions of Section 627.728, F.S., any insurer which issues a policy of private passenger motor vehicle insurance in this state shall be required to complete the underwriting of the policy and make a final determination of the correct premium for the coverage set forth in the insurance application within sixty (60) days after the effectuation of coverage. The requirements of this subsection shall not apply in the event that an incorrect premium was charged due to material misrepresentation or fraud on the part of the insured in the application for insurance. Insurers asserting a common law right of rescission or otherwise asserting rights to void insurance policies ab initio shall, within 90 days of rescinding a policy ~~taking such action~~, report electronically through the Florida Office of Insurance Regulation Industry Portal at www.floir.com ~~to the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Market Conduct Review, regarding any policies rescinded.~~ The report shall be on Form OIR-B3-493, "Report of Rescinded Policy," rev.06/2017 ~~7/90~~, which is hereby adopted and incorporated by reference. The report ~~form may be obtained from and~~ shall be ~~submitted~~ filed electronically through the Florida Office of Insurancve Regulation Industry Portal at www.floir.com. ~~to the Bureau of Property and Casualty Forms and Market Conduct Review, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0300.~~ The insurer shall retain its files on each rescinded policy for three (3) calendar years from the date of the report to the Office. Each file shall contain a copy of the initial application, a copy of the policy, copies of any claim forms filed, all documentation used by the insurer as a basis for its rescission, including the basis for any denial of coverage; and the name, business address and telephone number of any independent claims adjusting service where files may be located, if no longer in the possession of the insurer.

(2) In the event that an insurer issues a policy of private passenger motor vehicle insurance and timely determines that the policyholder has been charged an incorrect premium, the insurer shall provide notice to the policyholder as provided in Section 627.7282, F.S. Such notice shall include a period of time no less than ten (10) days and no greater than forty-five (45) days within which the policyholder has the option to pay the additional amount of premium due or to cancel the policy and demand a refund of any unearned premiums. The maximum 45-day time period shall not apply in the event the amount of the additional premium due is equal to or less than five percent of the correct premium.

(3) If the policyholder fails to timely respond to the notice referred to in subsection (2), above, the insurer shall cancel the policy as required in Section 627.7282, F.S., on a date no less than fourteen (14) days and no greater than forty-five (45) days after the notice, and return any unearned premium to the insured.

*Rulemaking Authority 624.308(1) FS. Law Implemented 624.424, 624.307(1), 626.9541(1)(o)3.a., 627.420, 627.421, 627.728,*

*627.7282 FS. History–New 7-23-88, Amended 9-18-90, Formerly 4-28.005, 4-167.002 Amended_____.*

**69O-157.111 Reporting Requirements.**

(1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percentage of the agent's total annual sales in this state and the amount of lapses of long-term care insurance policies sold by the agent as a percentage of the agent's total annual sales in this state.

(2) Every insurer shall report annually by June 30 the 10 percent of its agents with the greatest percentages of lapses and replacements as measured by subsection 69O-157.111(1), F.A.C., in the format as prescribed in Appendix J, "Long-Term Care Insurance Replacement and Lapse Reporting Form OIR-B2-1555" (06/2017 ~~2/09~~), which is incorporated herein by reference.

(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance in this state.

(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year in this state in the format as prescribed in Appendix J, "Long-Term Care Insurance Replacement and Lapse Reporting Form OIR-B2-1555" (06/2017 ~~2/09~~), which is incorporated herein by reference.

(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year in this state in the format as prescribed in Appendix J, "Long-Term Care Insurance Replacement and Lapse Reporting Form OIR-B2-1555" (06/2017 ~~2/09~~), which is incorporated herein by reference.

(6) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied in this state in the format as prescribed in Appendix E, "Claims Denial Reporting Form Long-Term Care Insurance for the State of Florida for the Reporting Year 20_" OIR-B2-1553 (06/2017 ~~2/09~~), which is incorporated herein by reference.

(7) For purposes of this section:

(a) "Policy" means only long-term care insurance;

(b) "Claim" means, subject to paragraph 69O-157.111(7)(c), F.A.C., a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Every insurer shall report annually by June 30 the information required by subsection 69O-157.116(8), F.A.C.

(9) Based on the provisions of Rule 69O-157.109, F.A.C., every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information, by March 1 of each year, in the format as prescribed in Appendix A, "Rescission Reporting Form For Long-Term Care Policies for the State of Florida For the Reporting Year 20__" OIR-B2-1552" (06/2017 ~~2/09~~), which is incorporated herein by reference.

(10) Reports required under this Rule 69O-157.111, F.A.C., shall be filed electronically through ~~with~~ the Florida Office of Insurance Regulation, Industry Portal at http://www.floir.com/iportal. ~~Division of Market Investigations.~~

(11) All forms adopted in this rule are available for review on the Office's web site at http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.424, 624.307(1), 627.9402, 627.9407(1), 627.410(7) FS. History–New 1-13-03, Formerly 4-157.111 Amended_____.*

Appendix J

# Long-Term Care Insurance
# Replacement and Lapse Reporting Form

For the State of

For the Reporting Year 20__

Company Name:

| | |
|---|---|
| Company Address | No., Street, unit #: |
| | City, State, Zip code: |

Company NAIC Number:

Contact Person:

Phone Number: ( ) -

Due: June 30 annually

Instructions: The purpose of this form is to report, on a statewide basis, information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

SUBMIT ELECTRONICALLY TO THE
**Florida Office of Insurance Regulation**
**Market Investigations**
HTTP://WWW.FLOIR.COM./IPORTAL

Listing of the 10% of Agents with the Greatest Percentage of Replacements:

| Agent's Name | Number of Policies Sold By This Agent | Number of Policies Replaced By This Agent | Number of Replacements As % of Number Sold By This Agent |
|---|---|---|---|
| | | | |

Listing of the 10% of Agents with the Greatest Percentage of Lapses:

| Agent's Name | Number of Policies Sold By This Agent | Number of Policies Lapsed By This Agent | Number of Lapses As % of Number Sold By This Agent |
|---|---|---|---|
| | | | |

Company Totals:

| | |
|---|---|
| Percentage of Replacement Policies Sold to Total Annual Sales | |
| Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar ear | |
| Percentage of Lapsed Policies to Total Annual Sales | |
| Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar ear. | |

Form OR-B2-1555 (Rev. 6/17
~~02/09~~) 690-157.111

**OFFICE OF INSURANCE REGULATION**

***Market Investigations***

Appendix E

Claims Denial Reporting Form
Long-Term Care Insurance
For the State of Florida
For the Reporting Year 20_

| | | |
|---|---|---|
| Insurer Name: | | |
| Insurer Address | No., Street, unit#: | |
| | City, State, Zip code: | |
| Insurer NAIC Number: | | |
| Contact Person: | | |
| Phone Number: ( ) - | | |
| Line of Business: | Individual: | Group: |

Due: June 30 annually

**Instructions:** The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

SUBMIT ELECTRONICALLY TO THE
**Florida Office of Insurance Regulation**
**Market Investigations**
HTTP://WWW.FLOIR.COM./IPORTAL

| | | State Data | Nationwide Data |
|---|---|---|---|
| 1 | Total Number of Long-Term Care Claims Reported | | |
| 2 | Total Number of Long-Term Care Claims Denied/Not Paid | | |
| 3 | Total Number of Claims Not Paid Due to Preexisting Condition Exclusion | | |
| 4 | Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met | | |
| 5 | Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4) | | |
| 6 | Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1) | | |
| 7 | Number of Long-Term Care Claims Denied Due to: | | |
| 8 | Long-Term Care Services Not Covered Under the Policy[2] | | |
| 9 | Provider/Facility Not Qualified Under the Policy[3] | | |
| 10 | Benefit Eligibility Criteria Not Met4 | | |
| 11 | Other | | |

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example - home health care claim filed under a nursing home only policy.
3. Example - a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples - a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

**OFFICE OF INSURANCE REGULATION**
***Market Investigations***

Appendix A

Rescission Reporting Form For
Long-Term Care Policies
For the State of Florida
For the Reporting Year 20_

| Insurer Name: |
|---|
| Address \| No., Street, unit #:<br>\| City, State, Zip code: |
| Phone Number: ( ) - |

Due: March 1st - Annually

**Instructions:** The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

SUBMIT ELECTRONICALLY TO THE
**Florida Office of Insurance Regulation**
**Market Investigations**
HTTP://WWW.FLOIR.COM./IPORTAL

| Policy Form# | Policy and Certificate # | Name of Insured | Date of Policy Issuance | Date(s) Claim(s) Submitted | Date of Rescission |
|---|---|---|---|---|---|
| | | | | | |

Detailed reason for rescission: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature

Name and Title (please type)

Date

Form 0IR-B2-1552 (Rev: 06/17 ~~02/09~~)
Rule 690-157.111

FLORIDA OFFICE OF INSURANCE REGULATION
REPORT OF RESCINDED POLICY

SUBMIT ELECTRONICALLY TO THE
OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS UNIT
HTTP://WWW.FLOIR.COM./IPORTAL

DATE SUBMITTED _____

COMPANY FEDERAL ID# _____
FULL COMPANY NAME _____
POLICY HOLDER'S NAME _____
DATE OF APPLICATION FOR COVERAGE _____
POLICY NUMBERS _____

HAS A CLAIM BEEN FILED ON THIS POLICY YES _ _ _ _ _ NO _____

IF YES:

CLAIMNO _ _ _ _ _ _ _ _ _ _ _ _ DATE _____

CLAIMNO _ _ _ _ _ _ _ _ _ _ _ _ DATE _____

CLAIMNO _ _ _ _ _ _ _ _ _ _ _ _ DATE _____

CLAIMNO _ _ _ _ _ _ _ _ _ _ _ _ DATE _____

DATE OF RECISSION OF THIS POLICY _____

69O-167.002
0IR-B3-493
REV. 06/ 2017
~~7/2006~~

THE FOLLOWING MUST BE RETAINED FOR THREE (3) CALENDAR YEARS FROM THE DATE SUBMITTED TO THE DEPARTMENT OF INSURANCE:

1. REPORT OF RESCINDED POLICY
2. INITIAL APPLICATION
3. COPY OF POLICY
4. COPY OF CLAIMS FORMS FILED
5. ALL DOCUMENTATION USED AS A BASIS FOR RESCISSION
6. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF ANY INDEPENDENT CLAIMS ADJUSTING SERVICE WHERE FILES MAY BE LOCATED

**INFORMATIONAL MEMORANDUM**
0IR-16-02M
ISSUED
**April 4, 2016**
Florida Office of Insurance Regulation
**Kevin M. McCarty, Commissioner**

All Private Passenger Motor Vehicle Insurers in the State of Florida

Electronic Submission of Report of Rescinded Policies

The Office of Insurance Regulation has implemented an electronic filing system to simplify reporting rescinded policies. Section 627.728, Florida Statutes, requires private passenger automobile insurers to complete the underwriting of the policy and make a final determination of the correct premium for coverage within sixty (60) days after the effectuation of coverage unless an incorrect premium was charged due to material misrepresentation or fraud on the part of the insured in the application for insurance. Rule 690-167.002, Florida Administrative Code, requires insurers asserting a common law right of rescission or otherwise asserting rights to void insurance policies ab initio, to report such action to the Office within ninety (90) days of taking such action.

The Office has developed an Excel spreadsheet as a template for reporting the same information collected in paper form 0IR-B3-493, "Report of Rescinded Policy," rev. 7/90. Insurers may now report rescissions of private passenger motor vehicle policies by utilizing the policy rescission feature found in the Data Collection and Analysis Modules (DCAM) System in the Industry Portal on the Office's website.

Each company should have an existing logon account for DCAM, which should be accessed at https://apps8.fldfs.com/DCAM/logon.aspx. If an account for the Industry Portal does not exist, follow directions on how to set up an account and create a filing at http://www.floir.com/siteDocuments/MCRP_DCAM_Account_Instructions.pdf. Detailed filing instructions for entering rescinded policy data are available within the template and at the following location: http://www.floir.com/siteDocuments/MCRP_Filing_Instructions.pdf.

This method for reporting rescinded policy information in the DCAM System is available immediately.

If you have questions regarding the submission of the Report of Rescinded Policies via the DCAM System, please contact the Market Research and Technology Unit, Florida Office of Insurance Regulation at MCRP@floir.com or at (850) 413-3147.

**69O-137.002 Annual Audited Financial Reports.**

(1) The purpose of this rule is to improve the Office's surveillance of the financial condition of insurers by requiring an annual audit of financial statements reporting the financial position and the results of operations of insurers by: (a) Independent certified public accountants (b) Communication of Internal Control Related Matters Noted in an audit, and (c) Management's Report of Internal Control over Financial Reporting.

(2)(a) Every authorized insurer, as defined in subsection (3), below, shall be subject to this rule. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and fewer than 1,000 policyholders or certificateholders of direct written policies nationwide at the end of the calendar year shall be exempt from this rule for the year (unless the Office makes a specific finding that compliance is necessary for the Office to carry out statutory responsibilities), except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders. Form OIR-DO-1431, (Rev. 7/01), "Audited Financial Statements Exemption Affidavit", is hereby incorporated by reference to be the form specified in Section 624.424(8)(b), F.S., for exemptions from compliance with the filing of an annual audited financial statement. Forms are available at http://www.floir.com/iportal. ~~This form is available from Life & Health Financial Oversight or Property & Casualty Financial Oversight at 200 East Gaines Street, Tallahassee, Florida 32399. The form is also available from the Office of Insurance Regulation's website located at the following address: www.floir.com.~~

(b) Foreign or alien insurers filing Audited Financial Reports in another state, pursuant to that state's requirement for filing of Audited Financial Reports which has been found by the Office to be substantially similar to the requirements herein, may, in lieu of the other requirements herein, be exempt from subsections (4) through (13) of this rule if:

1. A copy of the Audited Financial Report, Communications of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications which are filed with the other state are made available to the Office upon request in accordance with the filing dates specified in subsections (4), (11) and (12), respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada); and,

2. A copy of any Notification of Adverse Financial Condition Report filed with the other state are made available to the Office upon request within the time specified in subsection (10).

(c) This rule shall not prohibit, preclude, or in any way limit the Office from ordering and/or conducting and/or performing examinations of insurers under its rules.

(3) Definitions.

(a) "Accountant" and "Independent Certified Public Accountant" means an independent Certified Public Accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice. For Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(b) "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.

(c) "Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or Group of insurers, and audits of financial statements of the insurer or Group of insurers. The Audit committee of any entity that controls a Group of insurers may be deemed to be the Audit committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to paragraph (14)(e) for exercising this election. If an Audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the Audit committee.

(d) "Audited Financial Report" means and includes those items specified in subsection (5), below.

(e) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(f) "Independent board member" has the same meaning as described in paragraph (14)(c).

(g) "Insurer" means an authorized insurer as defined in Section 624.09, F.S.

(h) "Group of insurers" means those licensed insurers included in the reporting requirements of Chapter 628, Part IV, F.S. or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(i) "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in subparagraphs (5)(b)2. through 7. of this regulation, and includes those policies and procedures that:

1. Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflects the transactions and dispositions of assets;

2. Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in subparagraphs (5)(b)2. through 7. of this regulation, and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and,

3. Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in subparagraphs (5)(b)2. through 7. of this regulation.

(j) "Office" means the Office of Insurance Regulation.

(k) "SEC" means the United States Securities and Exchange Commission.

(l) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

(m) "Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in paragraph (3)(a).

(n) "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the Audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

(o) "Section 16 Report" means a Management's Report of Internal Control over Financial Reporting provided in subsection (16) of this rule.

(4) General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Report and Audit Committee Appointment.

(a) All insurers shall have an annual audit by an independent Certified Public Accountant and shall file an Audited Financial Report with the Office on or before June 1 for the year ended December 31 immediately preceding. The Office may require an insurer to file an Audited Financial Report earlier than June 1 with ninety (90) days advance notice to the insurer.

(b) Every insurer required to file an annual Audited Financial Report pursuant to this regulation shall designate a group of individuals as constituting its Audit committee, as defined in subsection (3). The Audit committee of an entity that controls an insurer may be deemed to be the insurer's Audit committee for purposes of this regulation at the election of the controlling person.

(5) Contents of Annual Audited Financial Report.

(a) The Annual Audited Financial Report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the state of domicile.

(b) The Annual Audited Financial Report shall include the following:

1. Report of independent Certified Public Accountant.

2. Balance sheet reporting admitted assets, liabilities, capital and surplus.

3. Statement of operations.

4. Statement of cash flows.

5. Statement of changes in capital and surplus.

6. Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions (incorporated by reference in subsection 69O-137.001(4), F.A.C.) and the NAIC *Accounting Practices and Procedures* Manual (incorporated by reference in subsection 69O-137.001(4), F.A.C.) and any other notes required by generally accepted accounting principles and shall also include reconciliation of differences, if any, between the audited statutory financial statements and the Annual Statement filed pursuant to Section 624.424(1), F.S., with a written description of the nature of these differences.

7. The financial statements included in the Audited Financial Report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the Annual Statement of the insurer filed with the Office, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an Audited Financial Report, the comparative data may be omitted.

(6) Designation of Independent Certified Public Accountant.

(a) Each insurer required by this rule to file an annual Audited Financial Report must, by December 31 of the year subject to audit, register with the Office in writing the name and address of the independent Certified Public Accountant or accounting firm retained to conduct the annual audit set forth in this rule.

(b) The insurer shall obtain a letter from the accountant, and file a copy with the Office, stating that the accountant is aware of the provisions of the Insurance Code and the Rules and Regulations of the state of domicile that relate to accounting and financial matters, and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Insurance Department, specifying the exceptions as he or she may believe appropriate.

(c) If an accountant who was the accountant for the immediately preceding filed Audited Financial Report is dismissed or resigns, the insurer shall within five (5) business days notify the Office of this event. The insurer shall also furnish the Office with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding that event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this paragraph include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this subsection are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter, and if not, stating the reasons for which he or she does not agree; and the insurer shall furnish the responsive letter from the former accountant to the Office together with its own.

(7) Qualifications of Independent Certified Public Accountant.

(a) The Office shall not recognize any person or firm as a qualified independent Certified Public Accountant if the person or firm:

1. Is not in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which the accountant is licensed to practice, or for a Canadian or British company, that is not a chartered accountant; or

2. Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as indemnification) with respect to the audit of the insurer.

(b) Except as otherwise provided in this rule, the Office shall recognize an independent Certified Public Accountant as qualified as long as he or she prepares reports, filings, and statements as required by the Florida Insurance Code, and conforms to the standards of his or her profession as contained in the Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Florida Board of Public Accountancy, or similar code.

(c)1. The lead (or coordinating) audit partner (having primary responsibility for the audit) may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the Office for relief from the above rotation requirement based on an unusual hardship to the insurer and a determination by the Office that the

accountant is exercising independent judgement that is not unduly influenced by the insurer. This application should be made at least thirty (30) days before the end of the calendar year. The Office shall consider the following factors in determining if the relief should be granted:

a. Number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm;

b. Premium volume of the insurer; and,

c. Number of jurisdictions in which the insurer transacts business.

2. The insurer shall file, with its annual statement filing, the approval for relief from paragraph (7)(c) with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic form acceptable to the NAIC.

(d) The Office shall neither recognize as a qualified independent Certified Public Accountant, nor accept an annual Audited Financial Report prepared in whole or in part by any natural person who:

1. Has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year or more under the law of the United States or any state thereof or under the law of any other country, which involves moral turpitude, without regard to whether a judgement of conviction has been entered by the court having jurisdiction in such case;

2. Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or

3. Has failed to detect or disclose material information in previous reports filed under the provisions of this rule.

(e) In accordance with the provisions of Sections 624.307 and 624.324, F.S., and in its own rules of departmental practice, the Office shall conduct a hearing to determine whether an independent Certified Public Accountant is qualified if Office records do not contain sufficient information to demonstrate that the Certified Public Accountant is qualified. Considering the evidence presented, the Office shall conclude that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual Audited Financial Report made pursuant to this rule, if the accountant fails to meet the qualifications and other requirements of this rule. If the accountant is found to be not qualified, the Office shall require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this rule. Upon determination by the Office that the accountant is not qualified to express an opinion on the financial statements in the annual Audited Financial Report made pursuant to this rule the insurer may request a hearing pursuant to Section 120.57, F.S.

(f) A qualified independent certified accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under

Chapter 631, F.S., the mediation or arbitration provisions shall operate at the option of the statutory successor.

(g)1. The Office shall not recognize as a qualified independent certified public accountant, nor accept an annual Audited Financial Report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

a. Bookkeeping or other services related to the accounting records or financial statements of the insurer;

b. Financial information systems design and implementation;

c. Appraisal or valuation services, fairness opinions, or contribution in-kind reports;

d. Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(I) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(II) The insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and

(III) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

e. Internal audit outsourcing services;

f. Management functions or human resources;

g. Broker or dealer, investment adviser, or investment banking services; or

h. Legal services or expert services unrelated to the audit;

2. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his own work, and cannot serve in an advocacy role for the insurer.

(h) Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from subparagraph (g)1. The insurer shall file with the Office a written statement discussing the reasons why the insurer

should be exempt from these provisions. If the Office finds, upon review of this statement, that compliance with this regulation would constitute an undue financial or organizational hardship upon the insurer, an exemption shall be granted.

(i) A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services that are not described in subparagraph (g)1. or that do not conflict with subparagraph (g)2. only if the activity is approved in advance by the Audit committee, in accordance with paragraph (j).

(j) All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the Audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity or:

1. The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

2. The services were not recognized by the insurer at the time of the engagement to be non-audit services; and,

3. The services are promptly brought to the attention of the Audit committee of the insurer and approved prior to the completion of the audit by the Audit committee or by one or more members of the Audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit committee.

(k) The Audit committee may delegate to one or more designated members of the Audit committee the authority to grant the preapprovals required by paragraph (l). The decisions of any member to whom this authority is delegated shall be presented to the full Audit committee at each of its scheduled meetings.

(l)1. The Office shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This subsection shall only apply to partners and senior managers involved in the audit.

2. The insurer shall file, with its annual statement filing, the approval for relief from subparagraph (l)1. with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(8) Consolidated or Combined Audits.

(a) An insurer may make written application to the Office for approval to file audited consolidated or combined financial

statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves, and the insurer cedes all of its direct and assumed business to the pool. In these cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

1. Amounts shown on the consolidated or combined Audited Financial Report shall be shown on the worksheet.

2. Amounts for each insurer subject to this section shall be stated separately.

3. Noninsurance operations may be shown on the worksheet on a combined or individual basis.

4. Explanations of consolidating and eliminating entries shall be included; and,

5. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the Annual Statements of the insurers.

(b)1. The application for approval to consolidate is required each year, and must be filed with the Office prior to the end of the calendar year for which the approval is being granted, except that applications for approval will be accepted after the end of such calendar year subject to the imposition of an administrative fine on each insurer involved in such application as provided for in Section 624.4211(2), F.S.

2. The amount of the fine shall be $50 per day for each day beyond the end of the calendar year, not to exceed an aggregate amount of $10,000 for the group of insurers requesting permission to file on a consolidated basis.

(c) Approval to consolidate or combine statements shall be granted unless the Office makes a specific finding that approval would prevent the Office from carrying out its statutory responsibilities.

(9) Scope of Audit and Report of Independent Certified Public Accountant. Financial statements furnished pursuant to subsection (5), above, shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, *Consideration of Internal Control in a Financial Statement Audit*, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to subsection (16), the independent certified public accountant should consider (as that term is defined in AU Section 120 of the Professional Standards of the AICPA, *Defining Professional Requirements in Statements on Auditing Standards*) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration should also be given to the other procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners

(incorporated by reference in Rule 69O-138.001, F.A.C.) as the independent Certified Public Accountant deems necessary.

(10) Notification of Adverse Financial Condition.

(a) The insurer required to furnish the annual Audited Financial Report shall require the independent Certified Public Accountant to report, in writing, within five (5) business days to the board of directors or its Audit committee any determination by the independent Certified Public Accountant that the insurer has materially misstated its financial condition as reported to the Office as of the balance sheet date currently under audit, or that the insurer does not meet the minimum capital and surplus requirement of the Florida Insurance Code as of that date. An insurer who has received a report pursuant to this paragraph shall forward a copy of the report to the Office within five (5) business days of receipt of said report and shall provide the independent Certified Public Accountant making the report with evidence of the report being furnished to the Office. If the independent Certified Public Accountant fails to receive the evidence within the required five (5) business day period, the independent Certified Public Accountant shall furnish to the Office a copy of its report within the next five (5) business days.

(b) An independent certified public accountant shall not be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with the above paragraph.

(c) If the accountant, subsequent to the date of the Audited Financial Report filed pursuant to this rule, becomes aware of facts which might have affected his report, the Office notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

(11) Communication of Internal Control Related Matters Noted in an Audit.

(a) In addition to the annual Audited Financial Report, each insurer shall furnish the Office with a written communication as to any unremediated material weaknesses in its Internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual Audited Financial Report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by AU Section 325 of the Professional Standards of the AICPA, *Communicating Internal Control Related Matters Identified in an Audit*) as of December 31 immediately preceding (so as to coincide with the Audited Financial Report discussed in subsection (4)) in the insurer's Internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

(b) The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses if the actions are not described in the accountant's communication.

(12) Accountant's Letter of Qualifications.

(a) The accountant shall furnish a letter to the insurer in connection with, and for inclusion in, the filing of the annual Audited Financial Report.

(b) The letter shall state:

1. That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the Florida Board of Public Accountancy, or similar code;

2. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent Certified Public Accountant. Nothing within this rule shall be construed as prohibiting the accountant from utilizing his or her staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

3. That the accountant understands the annual Audited Financial Report, and his or her opinion thereon will be filed in compliance with this rule, and that the Office will be relying on this information in the monitoring and regulation of the financial position of insurers;

4. That the accountant consents to the requirements of subsection (13), below, and that the accountant consents and agrees to make the workpapers as defined in subsection (13), below, available for review by the Office.

5. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and,

6. A representation that the accountant is in compliance with the requirements of subsection (7) of this rule.

(13) Definition, Availability, and Maintenance of Independent Certified Public Accountants Workpapers.

(a) Workpapers are the records kept by the independent Certified Public Accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, or commentaries prepared or obtained by the independent Certified Public Accountant in the course of his or her audit of the financial statements of an insurer, and which support the accountant's opinion.

(b) Every insurer required to file an Audited Financial Report pursuant to this rule shall require the accountant to make available for review by Office examiners all workpapers prepared in the conduct of the accountant's audit, and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Office or at any other reasonable place

designated by the Office. The insurer shall require that the accountant retain the audit workpapers and communications until the Office has filed a Report on Examination covering the period of the audit, but no less than seven (7) years from the date of the audit report.

(c) In the conduct of the aforementioned periodic review by the Office examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the Office. The reviews by the Office examiners shall be considered investigations, and all working papers and communications obtained during the course of the investigations shall be afforded the same confidentiality as other examination workpapers generated by the Office until the Report of Examination is filed by the Office.

(14) Requirements for Audit Committee.

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

(a) The Audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited Financial Report or related work pursuant to this rule. Each accountant shall report directly to the Audit committee.

(b) Each member of the Audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to paragraphs (e) and (3)(c).

(c) In order to be considered independent for purposes of this section, a member of the Audit committee may not, other than in his or her capacity as a member of the Audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof.

(d) If a member of the Audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an Audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(e) To exercise the election of the controlling person to designate the Audit committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the Office of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Office by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(f)1. The Audit committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit committee in accordance with the requirements of AU Section 380 of the Professional Standards of the AICPA, *Communication with Audit Committees*, including:

a. All significant accounting policies and material permitted practices;

b All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and,

c. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

2. If an insurer is a member of an insurance holding company system, the reports required by subparagraph (f)1. may be provided to the Audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit committee.

(g) The proportion of independent Audit committee members shall meet or exceed the following criteria:

| Prior Calendar Year Direct Written and Assumed Premiums | | |
|---|---|---|
| $0 – 300,000,000 | Over $300,000,000 – 500,000,000 | Over 500,000,000 |
| No minimum requirements. See also Notes A and B. | Majority (50% or more) of members shall be independent. See also Notes A and B. | Supermajority of members (75% or more) shall be independent. See also Note A. |

Note A: The Office has authority afforded by Section 624.4085, F.S., to require the entity's board to enact improvements to the independence of the Audit committee membership if the insurer is in a Risk Based Capital action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit committees with at least a supermajority of independent Audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(h) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the Office for a waiver from the subsection (14) requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from

subsection (14) with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(15) Conduct of Insurer in Connection with the Preparation of Required Reports and Documents.

(a) No director or officer of an insurer shall, directly or indirectly:

1. Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

2. Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

(b) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of paragraph (b) of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

1. To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the Office or generally accepted auditing standards);

2. Not to perform audit, review or other procedures required by generally accepted auditing standards;

3. Not to withdraw an issued report; or

4. Not to communicate matters to an insurer's Audit committee.

(16) Management's Report of Internal Control over Financial Reporting.

(a) Every insurer required to file an Audited Financial Report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or Group of insurers' Internal control over financial reporting, as these terms are defined in subsection (3). The report shall be filed with the Office along with the Communication of Internal Control Related Matters Noted in an Audit described under subsection (11). Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding.

(b) Notwithstanding the premium threshold in paragraph (16)(a), the Office shall require an insurer to file Management's Report of Internal Control over Financial Reporting if the insurer is in any Risk Based Capital level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition. "Hazardous financial condition" shall mean any of the conditions that subject an insurer to suspension or revocation of its certificate of authority as provided in Section 624.418, F.S.

(c) An insurer or a Group of insurers that is:

1. Directly subject to Section 404;

2. Part of a holding company system whose parent is directly subject to Section 404;

3. Not directly subject to Section 404 but is a SOX Compliant Entity; or

4. A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity; may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section's requirement provided that those internal controls of the insurer or Group of insurers having a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements (those items included in subparagraphs (5)(b)2. through (5)(b)7. of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or Group of insurers' audited statutory financial statements (those items included in subparagraphs (5)(b)2. through (5)(b)7. of this rule) excluded from the Section 404 Report. If there are internal controls of the insurer or Group of insurers that have a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or Group of insurers may either file (i) a subsection (16) report, or (ii) the Section 404 Report and a subsection (16) report for those internal controls that have a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements not covered by the Section 404 Report.

(d) Management's Report of Internal Control over Financial Reporting shall include:

1. A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

2. A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

3. A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

4. A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

5. Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding, after the effective date of this rule. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal controls over financial reporting;

6. A statement regarding the inherent limitations of internal control systems; and,

7 Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

(e) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in paragraph (d) above, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

1. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

2. Management's Report on Internal Control over Financial Reporting, required by paragraph (a) above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Office.

(17) Exemptions and Effective Dates.

(a) Upon written application of any insurer, the Office shall grant an exemption from compliance with any and all provisions of this rule if the Office finds, upon review of the application, that compliance with this regulation would constitute an undue financial or organizational hardship upon the insurer.

(b) Domestic insurers shall comply with this rule for the year ending December 31, 2010 and each year thereafter.

(c) Foreign insurers shall comply with this rule for the year ending December 31, 2010 and each year thereafter.

(d) The requirements of paragraph (7)(c) shall be in effect for audits of the year ending December 31, 2010 and thereafter.

(e) The requirements of subsection (14) are to be in effect for audits of the year ending December 31, 2010. An insurer or Group of insurers that is not required to have independent Audit committee members or only a majority of independent Audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements discussed in this paragraph due to changes in premium shall have one (1) year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence

requirements discussed in this paragraph. Likewise, an insurer that becomes subject to one of the independence requirements discussed in this paragraph as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

(f) The requirements of subsection (16) and other modified sections, except for subsection (14) covered above, are effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or Group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

(18) Canadian and British Companies.

(a) In the case of Canadian and British insurers, the annual Audited Financial Report shall be defined as the annual statement of total business on the form filed by the companies with their supervision authority duly audited by an independent chartered accountant.

(b) For these insurers, the letter required in paragraph (6)(b), above, shall state that the accountant is aware of the requirements relating to the annual Audited Financial Report filed with the Office pursuant to subsection (4), above, and shall affirm that the opinion expressed is in conformity with these requirements.

(19) Severability Provision.

If any section or portion of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected.

(20) Standards Incorporated by Reference.

(a) The following standards are hereby incorporated by reference:

1. AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit;

2. AU Section 120 of the Professional Standards of the AICPA, *Defining Professional Requirements in Statements on Auditing Standards;*

3. Volume 1, Section AU 561 of the Professional Standards of the AICPA;

4. AU Section 325 of the Professional Standards of the AICPA, *Communicating Internal Control Related Matters Identified in an Audit*; and,

5. AU Section 380 of the Professional Standards of the AICPA, *Communication with Audit Committees.*

(b) The standards incorporated in this section are available at the American Institute of CPAs (AICPA) website at: http://www.aicpa.org/Publications.

*Rulemaking Authority 624.308(1), 624.4085, 624.424(8)(e) FS. Law Implemented 624.307(1) ,624.424, 624.324, 624.424(8) FS. History–New 3-31-92, Amended 3-14-94, 8-17-98, 4-4-01, 8-14-02, Formerly 4-137.002, Amended 11-3-05, 9-21-10 Amended_____.*

**69O-137.003 Premium Growth Reporting.**

Section 624.4243(3), F.S., requires that a form for reporting premium growth be adopted by rule for each insurer that has been authorized to transact property and casualty insurance in Florida for less than three years. Form OIR-A1-1229 (rev. 7/01), entitled "Office of Insurance Regulation Premium Growth Reporting Form," is hereby incorporated by reference to be the form specified in Section 624.4243(3), F.S., for reporting premium growth. Forms are available at http://www.floir.com/iportal. ~~This form may be obtained from the Document Processing Section, Division of Administration, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0311. Forms are additionally available and may be printed from the office's web site: www.dfs.state.fl.us.~~ All forms may be reproduced at will.

*Rulemaking Authority 624.4243(3) FS. Law Implemented 624.4243 FS. History–New 3-26-98, Amended 3-27-02, Formerly 4-137.003 Amended_____.*

**69O-137.011 Reinsurance Summary Statement.**

Section 624.610(11), F.S., requires each domestic or commercially domiciled insurer ceding directly written risks of loss to file with the office one copy of a summary statement containing information about each treaty. The required information shall be filed on Form OIR-D0-1433 (rev. 07/01), entitled "Reinsurance Summary Statement," which is hereby incorporated by reference. Form OIR-D0-1433 shall be filed within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty. Forms are available and shall be filed electronically at http://www.floir.com/iportal. ~~This form may be obtained from the Document Processing Section, Division of Administration, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0311. Forms are additionally available and may be printed from the office's web site: www.dfs.state.fl.us.~~ All forms may be reproduced at will.

*Rulemaking Authority 624.308(1) FS. Law Implemented 624.424, 624.610(11) FS. History–New 3-27-02, Formerly 4-137.011, Amended*_____

**69O-138.005 Exams By Non Employees.**

(1) The Office is required by Section 624.316(1)(a), F.S., to examine the affairs, transactions, accounts, records and assets of each authorized insurer and of the attorney in fact of a reciprocal insurer. The examination standards with which the Office must comply are established by statute and adopted by rule. The statutes and rules meet the requirements of the National Association of Insurance Commissioners for accreditation in the area of financial regulation. Any report received from another jurisdiction pursuant to this rule is received for purposes of assessing the financial condition of the insurer and not any other purpose. Any information contained in such a report which would be the subject of a market conduct report prepared by this Office is not relevant to this rule. The Office will be bound only by the information relevant to the financial condition of the insurer.

(2) Section 624.316(2)(b), F.S., requires the Office to examine each insurer applying for an initial Certificate of Authority to transact business in this state before granting the initial certificate. For purposes of this provision, for examinations commenced on or after January 1, 1994, the Office will, in the absence of a reasonable belief that the examination report is not accurate, accept the examination report of a foreign insurer as prepared by the insurance office of the insurer's domiciliary state if the domiciliary insurance office is accredited by the National Association of Insurance Commissioners in the area of financial regulation or if the examination is performed under the supervision of or with the participation of an examiner from a state which is so accredited and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their Insurance Office.

(3) Section 624.316(2)(c), F.S., permits the Office, in lieu of making its own examination of a foreign insurer, to accept a full report of the most recent examination of a foreign insurer, as certified to by the insurance supervisory official of another state. For purposes of this provision, for examinations commenced on or after January 1, 1994, the Office will, in the absence of a reasonable belief that the examination report is not accurate, accept the examination report of a foreign insurer as prepared by the insurance office of the insurer's domiciliary state if the domiciliary insurance office is accredited by the National Association of Insurance Commissioners in the area of financial regulation or if the examination is performed under the supervision of or with the participation of an examiner from a state which is so accredited and who, after a review of the examination work papers and report, states under oath that the examination was performed in a manner consistent with the standards and procedures required by that Insurance Office. Such reports of examination must be certified to by the insurance supervisory official of the state of domicile and mailed to the Office within 10 calendar days of receipt by the insurer, except that, if the report shows that the insurer has materially misstated its financial condition or that the insurer does not meet the minimum capital and surplus requirements of the Florida Insurance Code, the report must be sent to the Office within 5 business days of receipt using a facility that offers next day delivery

service. A material misstatement is defined as a collective amount of 10% or more of total assets, total liabilities, or total capital and surplus.

(4) Section 624.316(2)(e), F.S., allows the Office to conduct examinations of an insurer by contracting for the services of an independent Certified Public Accountant, an actuary, a reinsurance specialist, an investment specialist, information technology specialist, or any combination of these individuals, as the particular circumstances of the examination require. An examination performed pursuant to this subsection must meet the requirements of subsection (1).

(a) An actuary meeting the criteria established in Rules 69O-138.043 or 69O-170.031, F.A.C., will qualify to conduct an examination under this subsection.

(b)1. A reinsurance specialist shall be qualified to conduct an examination under this subsection if that contractor can demonstrate competency by education and experience to perform such an examination. Competency by education and experience shall be demonstrated if any one of the following is true:

a. An individual qualifies as an actuary pursuant to either Rules 69O-138.043 or 69O-170.031, F.A.C., and has at least one years' experience with the kind of reinsurance which will be the subject of the examination.

b. An individual has a bachelor's degree from an accredited college or university and four years of professional experience in insurance/reinsurance accounting or in reinsurance transactions. A master's degree from an accredited college or university in accounting, insurance, or risk management can substitute for one year of the required experience. Professional experience as described above can substitute on a year-for-year basis for the required education.

c. An individual is in good standing with the Society of Financial Examiners and is certified by that organization to be eligible to hold the title of Certified Financial Examiner.

2. In selecting a person as a reinsurance specialist the Office shall consider the individual's experience, knowledge, skill, and abilities as they relate to the needs of the examination to be performed. This consideration shall include the individual's experience with the kind of insurance which is the subject of the examination; knowledge of accounting principles, practices and procedures; ability to prepare financial statements to reflect the reinsurance transactions; ability to provide professional and technical assistance; understanding of risk transfer as defined in the NAIC Examiners Handbook and the NAIC Accounting Practices and Procedures and Annual Statement Instruction Manuals, as adopted in Rule 69O-137.001, F.A.C.; and the ability to evaluate claims experience, both reported and incurred but not reported, relevant to the type of insurance which is the subject of the examination.

(c)1. An investment specialist shall be qualified to conduct an examination under this subsection if that contractor can demonstrate competency by education and experience to perform such an examination in that capacity. Competency by education and experience shall be demonstrated if any one of the following is true:

a. An individual has a bachelor's degree from an accredited college or university and four years of professional experience in the capacity for which the contractor is to perform. A master's degree from an accredited college or university in accounting, or finance can substitute for one year of the required experience. Professional experience as described above can substitute on a year-for-year basis for the required education.

b. An individual is in good standing with the Society of Financial Examiners and is certified by that organization to be eligible to hold the title of Certified Financial Examiner.

2. In selecting a person as an investment specialist the Office shall consider the individual's experience, knowledge, skill, and abilities as they relate to the needs of the examination to be performed.

(d)1. An information technology specialist shall be qualified to conduct an examination under this subsection if that contractor can demonstrate competency by education and experience to perform such an examination in that capacity. Competency by education and experience shall be demonstrated if the individual has a bachelor's degree from an accredited college or university and four years of professional experience in the capacity for which the contractor is to perform. A master's degree from an accredited college or university in information technology or a similar field can substitute for one year of the required experience. Professional experience as described above can substitute on a year-for-year basis for the required education.

2. In selecting a person as an information technology specialist the Office shall consider the individual's experience, knowledge, skill, and abilities as they relate to the needs of the examination to be performed.

(e) The firm selected by the office to perform the examination shall have no conflicts of interest that might affect its ability to independently perform its responsibilities on the examination.

(f) The rates charged to the insurer being examined under the contract shall be consistent with rates charged by other firms in a similar profession and shall be comparable with the rates charged for comparable examinations. The rates and terms shall be set forth in the contract.

(g) Contractors may submit a curriculum vitae detailing their experience and qualifying credentials to the Office, as well as a proposed hourly rate for services to be performed. The acceptability of a contractor to the Office shall be determined based on consideration of the firm's professional competence, objectivity, and that the rates charged are consistent with rates charged by other firms in a similar profession, as referenced in subsection (4), above, providing comparable services, so as to protect the examined

insurer from being overcharged for the examination. Once a contractor has been accepted by the Office, they will be placed on a list of eligible examination contractors.

(h) In selecting contractors to conduct a specific examination, the Office shall consider the contractor's experience, knowledge, skill, and abilities as they relate to the needs of the examination to be performed. This consideration shall include the contractor's experience with the kind of insurance which is the subject of the examination.

(i) After a contractor has been selected for a specific examination the Office shall enter into a contract with the contractor, detailing the scope of work for the engagement. The contract shall include a provision that the contractor has no conflict of interest that might affect its ability to independently perform its responsibilities. The contractor shall submit all requests for payment to the Office in the manner prescribed by the contract.

(j) All requests for reimbursement of travel expenses are to be made on Form DFS-C1-500 (Rev.12/13 ~~07/08~~). This form is incorporated by reference and adopted by this rule for this purpose. It is available at http://www.floir.com/sitedocuments/DFS-C1-500.xls.

(k) Upon receipt and review of the contractor's request for payment, the Office will invoice the insurer being examined and the insurer shall make payment to the Office pursuant to Sections 624.316(2)(e)3. and 624.320(2), F.S.

(l) Upon receipt of the payment from the insurer being examined, the Office will make payment to the contractor in accordance with the rates and terms set out in the completed Form OIR-A1-1976, Professional Services Agreement for Non Employee Examination.

(m) Forms OIR-A1-1976, Professional Services Agreement for Non Employee Examination (12-08); OIR-A1-1977, Scope of Services Addendum to Professional Services Agreement for Non Employee Examination (12-08); and OIR-A1-1978, Amendment to Scope of Services Addendum (12-08), are incorporated by reference and adopted herein as the contracts by which the contractors are retained. All forms referenced in this rule are available for viewing ~~at the Office's homepage~~ at www.floir.com/iportal.

(5) Section 624.316(2)(f), F.S., requires the examination of a domestic insurer once each year for any domestic insurer that has continuously held a Certificate of Authority for less than 3 years. For purposes of an examination under this subsection, the 3 years shall constitute the time period from the date the Certificate of Authority is granted through the following 3 full calendar years in which the insurer has been licensed. The examination must cover the preceding fiscal year or the time period since the last examination.

*Rulemaking Authority 624.308(1), 624.316(2) FS. Law Implemented 624.307(1), 624.316, 624.3161, 624.320, 624.321(1), 624.424 FS. History–New 6-9-93, Amended 11-23-94, 4-4-99, Formerly 4-138.005, Amended 7-1-09 Amended_____.*

**69O-138.021 Special Consent Investments.**

(1) This rule implements the provisions of Section 625.331, F.S., and applies to all authorized insurers as defined in Section 624.09, F.S.

(2) Automatic Revocation and Renewal Procedure.

(a) Each special consent investment currently on an insurer's statutory balance sheet, which has been approved or granted by the Office, either expressly or by implication, prior to December 31, 1991, is revoked 90 days after the effective date of this rule. Each insurer that currently has a special consent investment on its statutory balance sheet approved or granted by the Office, either expressly or by implication, on or before December 31, 1991, shall resubmit the investment to the Office for renewal pursuant to provisions of paragraph (2)(c) of this subsection.

(b) On or after January 1, 1992, all special consent investments approved or granted by the Office shall have an effective duration of one year or less, but may be for a period in excess of 1 year if the approval contains a specific expiration date for that special consent. Unless otherwise specified, all special consents shall expire at midnight on March 15, of the year following the date the special consent was granted.

(c) All requests for special consent investments shall be clearly labeled as such~~, shall be submitted in writing,~~ and shall contain the following information: name and NAIC code number of the insurer requesting the special consent; nature and amount of the proposed investment; requested dates of approval and expiration; reason for the special consent request; date of submission for approval; and information regarding any previous special consents granted to the insurer for the same or nearly the same investments. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 625.331 FS. History–New 6-15-92, Formerly 4-138.02 Amended_____.*

**69O-138.041 Scope.**

(1) This part shall apply to all life and health insurance companies and fraternal benefit societies doing business in this state, and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities, or accident and health insurance business in this state. This part shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the Office shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

(2) This rule shall be applicable to all annual statements filed with the Office after the effective date of this rule. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Rule 69O-138.046, F.A.C., of this part, and a memorandum in support thereof in accordance with Rule 69O-138.047, F.A.C., of this part, shall be required each year. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking Authority 624.308(1), 625.121(3)(a) FS. Law Implemented 624.307(1), 624.316(1)(c), 624.424(1), 625.121(3) FS. History–New 5-18-93, Amended 2-16-94, 1-23-03, Formerly 4-138.041 Amended_____.*

**69O-138.043 General Requirements.**

(1) Submission of Statement of Actuarial Opinion.

(a) Included on or attached to Page 1 of the annual statement for each year, beginning with the year in which this part becomes effective, shall be the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Rule 69O-138.046, F.A.C.

(b) Upon written request by the company, the Office will, for good cause, grant an extension of the date for submission of the statement of actuarial opinion. Good cause includes the occurrence of an event or circumstance beyond the control of the company, which prevents compliance and could not be reasonably remedied or foreseen by the company.

(2) Qualified Actuary.

(a) The company shall give the Office, prior to or concurrent with the filing of the first annual statement to which this rule applies, written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in such notice that the person meets the requirements set forth in this paragraph (2)(b) below.

(b) Any appointed actuary will be considered to be a "Qualified Actuary" if he:

1. Is a member in good standing of the American Academy of Actuaries;

2. Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

3. Is familiar with the valuation requirements applicable to life and health insurance companies;

4. Has not been found by the Office (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

a. Violated any provision of, or any obligation imposed by, the Insurance Code or other state or federal law relating to insurance in the course of his or her dealings as a qualified actuary;

b. Been found guilty of or pleaded guilty or nolo contendere to fraudulent or dishonest practices without regard to whether a judgment of conviction has been entered by the court having jurisdiction in such case;

c. Demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

d. Submitted to the Office during the past 5 years, pursuant to this part, an actuarial opinion or memorandum that the Office rejected because it did not meet the provisions of this part including standards set by the Actuarial Standards Board; or

e. Resigned or been removed as an appointed actuary within the past 5 years as a result of acts or omissions indicated in any

adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and,

5. Has not failed to notify the Office of any action taken by any insurance supervisory official of any other state similar to that under subparagraph (2)(b)4. above.

(c) Once notice is furnished, no further notice is required with respect to this person provided the company shall give the Office written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in paragraph 69O-138.043(2)(b), F.A.C. Notice must be prior to or concurrent with the termination of the actuary's appointment or retention, or upon discovery that the actuary no longer meets the requirements set forth in paragraph 69O-138.043(2)(b), F.A.C. All filings shall be submitted electronically to http://www.floir.com/iportal.

(d) If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

(3) Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this part shall:

(a) Conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and on any additional standards under this part, which standards are to form the basis of the statement of actuarial opinion in accordance with Rule 69O-138.046, F.A.C., of this part; and,

(b) Be based on methods of analysis deemed appropriate for such purposes by the Actuarial Standards Board.

(4) Liabilities to be Covered.

(a) Under authority of subsection (3) of the Standard Valuation Law, Section 625.121, F.S., the statement of actuarial opinion shall apply to all in-force business on the statement date regardless of when or where issued, e.g., reserves of Exhibits 5, 6 and 7, and claim liabilities in Exhibit 8, Part I of the Annual Statement, and equivalent items in the separate account statement or statements.

(b) If the appointed actuary, as the result of asset adequacy analysis, determines that a reserve shall be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in subsections 7, 11, 12, and 14 of the Standard Valuation Law, the company shall establish the additional reserve.

(c) Additional reserves established under paragraph (4)(b) above and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves will not be deemed an adoption of a lower standard of valuation.

*Rulemaking Authority 624.308(1), 625.121(3)(a) FS. Law Implemented 624.307(1), 624.316(1)(c), 624.424(1), 625.121(3) FS. History–New 5-18-93, Amended 2-16-94, 1-23-03, Formerly 4-138.043 Amended_____.*

**69O-141.003 Plan of Correction.**

(1) The plan referred to in Section 624.81(4), F.S., shall where applicable include the actions specified in subsection (2), below.

(2) The Office shall if applicable, and upon consent of the supervised insurer:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor;

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period;

(e) Reduce the total amount of an insurer's present and potential liability for policy benefits by reinsurance;

(f) Reduce, suspend or limit an insurer's volume of business being accepted or renewed;

(g) Reduce an insurer's general insurance and commission expenses by specified methods;

(h) Increase an insurer's capital and surplus;

(i) Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

(j) Require an insurer to file reports clearly and accurately reflecting the market value of the insurer's assets;

(k) Require an insurer to limit or withdraw from certain investments or to discontinue certain investment practices;

(l) Require an insurer to document the adequacy of premium rates in relation to the risks insured;

(m) Require an insurer to file, in addition to regular annual statements, interim financial reports;

(n) Impose restricted activities pursuant to Section 624.83, F.S.; or

(o) Appoint a deputy supervisor to oversee and monitor the operations of the insurer.

(3) The requirements of a corrective plan will vary depending upon the specific circumstances surrounding the troubled situation. Some of the elements necessary for a corrective plan include but are not limited to the following:

(a) An executive summary identifying the objectives to be attained in the plan, with key implementation dates and a projected date for full statutory compliance;

(b) Background and description of the company, describing the insurer's history, ownership structure, relationships with affiliates, management structure, key employees, and overall operating structure of the organization;

(c) The financial condition of the insurer, summarizing major categories of revenues and expenses, assets and liabilities, and debt and capital structure for the past two years based on actual results, and for the next three years based on forecasted results;

(d) The causes of the unsound or hazardous conditions giving rise to supervision proceedings;

(e) Corrective action required, identifying operational changes, contractual changes, management changes, and changes in internal control systems;

(f) Specific business plans by function, including current marketing plans, company operations such as claims processing, projected monthly financial forecasts for at least a two-year period and quarterly financial forecasts thereafter; and,

(g) Monitoring and reporting systems providing a periodic review of progress and comparisons of actual results with the corrective plan objectives.

(4) Any reports submitted to the Office pursuant to any approved corrective plan shall be electronically filed at http://www.floir.com/iportal ~~addressed to the Bureau of Administrative Services within the Office of Insurance Regulation~~ unless otherwise indicated through a consent order. All other reports required by statute or rule shall be submitted in the manner required by such statute or rule, regardless of whether the insurer is in administrative supervision.

(5) Any notice, request, or other communication received by an insurer while in administrative supervision from any person acting for the Office, but not responsible for the administrative supervision, ~~employed by the Bureau of Administrative Services,~~ shall be reported to the person in the office responsible for the administrative supervision ~~Bureau of Administrative Services~~ by the insurer within five (5) days of receipt.

*Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.610, 624.80, 624.81, 625.012, 625.172, 625.302, 625.330, 625.332, 625.338 FS. History–New 1-30-91, Formerly 4-93.003, Amended 5-5-92, Formerly 4-141.003 Amended_____.*

**69O-143.013 Exemption from Section 625.76 of the Act of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar Plans.**

Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of Section 625.76, F.S., of the Act, if the plan meets the following conditions:

(1) The plan has been approved directly or indirectly;

(a) By the affirmative votes of the holders of a majority of the securities of such insured present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the State of Florida; or

(b) By the written consent of the holders of a majority of the securities of such insurer entitled to vote: provided, however, that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the Office ~~Director~~ in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of;

1. The date the Act first applies to such insurer; or

2. The acquisition of an equity security for which exemption is claimed.

Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with~~, or mailed for filing to~~, the Office ~~Director~~ electronically at http://www.floir.com/iportal not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this paragraph, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(2) If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then

such discretion shall be exercised only as follows:

(a) With respect to the participation of directors.

1. By the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

2. By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

3. Otherwise in accordance with the plan, if the plan (i) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or (ii) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

(b) With respect to the participation of officers who are not directors.

1. By the board of directors of the insurer or a committee of three or more directors; or

2. By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

For the purpose of this paragraph, a director or committee member shall be deemed to be a disinterested person only if such person is not at the time such discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(c) The provisions of this paragraph shall not apply with respect to any option granted, or other equity security acquired, prior to the effective date of the Act.

(3) As to each participant or as to all participants the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by

participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargements of rights.

(4) Unless the context otherwise requires, all terms used in this section shall have the same meaning as in the Act or elsewhere in these rules or regulations. In addition, the following definitions apply:

(a) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

(b) The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in section 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used herein, provided however, that for the purposes hereof an option which meets all of the conditions of said section, of the Internal Revenue Code, other than the date of issuance, shall be deemed to be a "restricted stock option."

(c) The term "exercise of an option, warrant or right" contained in the parenthetical clause of the first paragraph of this rule shall not include:

1. The making of any election to receive under any plan an award of compensation in the form of stock or credits therefor, provided that such election is made prior to the making of the award, and provided further that such election is irrevocable until at least six months after termination of employment;

2. The subsequent crediting of such stock;

3. The making of any election as to a time for delivery of such stock after termination of employment, provided that such election is made at least six months prior to any such delivery;

4. The fulfillment of any condition to the absolute right to receive such stock; or

5. The acceptance of certificates for shares of such stock.

*Rulemaking Authority 625.82 FS. Law Implemented 624.424, 625.76 FS. History–New 4-23-66, Amended 1-22-68, Repromulgated 12-24-74, Formerly 4-19.13, 4-19.013, 4-143.013 Amended_____.*

**69O-143.030 Information to Be Furnished to Stockholders.**

(1) No solicitation subject to this chapter shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Rule 69O-143.036, F.A.C.

(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection (3) hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS under the heading "Financial Reporting to Stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

(3) Two copies of each report sent to the stockholders pursuant to this section shall be filed electronically with the Office at http://www.floir.com/iportal ~~mailed to the Director~~ not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the Office ~~Director~~, pursuant to subsection (1) of Rule 69O-143.032, F.A.C., of this rule, whichever date is later.

(4) If no solicitation is being made by management of the insurer with respect to any annual or other meeting, such insurer shall mail to every stockholder of record at least twenty days prior to the meeting date, an information statement as required in Rule 69O-143.028, F.A.C., containing the information called for by subsections (2) and (5) through (15) of Rule 69O-143.036, F.A.C., which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting. If such information statement relates to an annual meeting at which directors are to be elected, it shall be accompanied by an annual report to such stockholders in the form provided in subsection (2) of this rule.

*Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 628.152 FS. History–New 3-18-65, Amended 1-22-68, Repromulgated 12-24-74, Formerly 4-17.05, 4-17.005, 4-143.030 Amended_____.*

**69O-143.032 Material Required to Be Filed.**

(1) Two preliminary copies of the information statement or the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the Office ~~Director~~ at least fifteen days prior to the date definitive copies of such material are first sent or given to stockholders, or such shorter period prior to that date as the Office ~~Director~~ may authorize upon a showing of good cause therefor.

(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the Office ~~Director~~ at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the Office ~~Director~~ may authorize upon a showing of good cause therefor.

(3) Two definitive copies of the information statement or the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with~~, or mailed for filing to,~~ the Office ~~Director~~ not later than the date such material is first sent or given to the stockholders.

(4) Where any information statement or proxy statement, form of proxy or other material filed pursuant to this chapter is amended or revised, two of the copies shall be marked to clearly show such changes.

(5) Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

(6) Notwithstanding the provisions of subsections (1) and (2) hereof and of subsection (5) of Rule 69O-143.035, F.A.C., copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Office ~~Director~~ prior to use or publication. Definitive copies, however, shall be filed with ~~or mailed for filing to~~ the Office ~~Director~~ as requested by subsection (3) hereof not later than the date such material is used or published. The provisions of subsections (1) and (2) hereof and subsection (5) of Rule 69O-143.035, F.A.C., shall apply, however, to any reprints or reproductions of all or any part of such material. All filings made pursuant to this rule shall be submitted electronically at http://www.floir.com/iportal.

*Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 628.152 FS. History–New 3-18-65, Repromulgated 12-24-74, Formerly 4-17.07, 4-17.00, 4-143.032 Amended _____.*

**69O-143.035 Special Provisions Applicable to Election Contests.**

(1) Applicability. This section shall apply to any solicitation subject to this chapter by any person or group for the purpose of opposing a solicitation subject to this chapter by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

(2) Participant or Participant in a Solicitation.

(a) For purposes of this section the terms "participant" and "participant in a solicitation" include:

1. The insurer;

2. Any director of the insurer, and any nominee for whose election as a director proxies are solicited;

3. Any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(b) For the purposes of this section the term "participant" and "participant in a solicitation" do not include:

1. A bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase of sale of stock and who is not otherwise a participant;

2. Any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties;

3. Any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;

4. Any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or

5. Any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

(3) Filing of Information Required by Rule 69O-143.037, F.A.C.

(a) No solicitation subject to this section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the Office ~~Director~~ may authorize upon a showing of good cause therefor, there has been filed with the Office ~~Director~~ by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by Rule 69O-143.037, F.A.C., and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Office's ~~Director's~~ comments have been received and complied with.

(b) Within five business days after a solicitation subject to this section is made by the management of an insurer, or such longer periods as the Office ~~Director~~ may authorize upon a showing of good cause therefor, there shall be filed with the Office ~~Director~~ by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Rule 69O-143.037, F.A.C.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the information specified in Rule 69O-143.037, F.A.C., shall be filed with the Office ~~Director~~, by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a), (b) and (c) of this subsection, additional persons become participants in a solicitation subject to this rule, there shall be filed with the Office ~~Commissioner~~, by or on behalf of each such person, a statement in duplicate containing the information specified by Rule 69O-143.037, F.A.C., within three business days after such person becomes a participant, or such longer period as the Office ~~Director~~ may authorize upon a showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the Office ~~Director~~.

(f) Each statement and amendment thereto filed, pursuant to this subsection shall be part of the public files of the Office ~~Director~~.

(4) Solicitations Prior to Furnishing Required Proxy Statement. Notwithstanding the provisions of subsection (1) of Rule 69O-143.030, F.A.C., a solicitation subject to this section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Rule 69O-143.036, F.A.C., with respect to such solicitation, provided that:

(a) The statements required by subsection (3) hereof are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to stockholders prior to the time the written proxy statement required by subsection (1) of Rule 69O-143.030, F.A.C., is furnished to such persons; provided, however, that this paragraph (4)(b) shall not apply where a proxy statement then meeting the requirements of Rule 69O-143.036, F.A.C., has been furnished to stockholders.

(c) At least the information specified in paragraphs (3)(b) and (c) of the statements required by subsection (3) hereof to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Rule 69O-143.036, F.A.C., with respect to a solicitation is

sent or given to stockholders at the earliest practicable date.

(5) Solicitations Prior to Furnishing Required Written Proxy Statements – Filing Requirements. Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by subsection (1) of Rule 69O-143.030, F.A.C., shall be filed with the Office ~~Director~~ in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or such shorter period as the Office ~~Director~~ may authorize upon a showing of good cause therefor.

(6) Application of this section to Report. Notwithstanding the provisions of subsections (1) and (2) of Rule 69O-143.030, F.A.C., two copies of any portion of the report referred to in subsection (1) of Rule 69O-143.030, F.A.C., which comments upon or refers to any solicitation subject to this section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Office ~~Director~~ as proxy material subject to this rule. Such portion of the report shall be filed with the Office ~~Director~~, in preliminary form, at least five business days prior to the date copies of the report are first sent or given to the stockholders. All filings required by this rule shall be filed electronically at http://www.floir.com/iportal.

*Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 628.152 FS. History–New 3-18-65, Repromulgated 12-24-74, Formerly 4-17.10, 4-17.010, 4-143.035 Amended_____.*

**69O-143.042 Custody Agreement; Requirements.**

(1) A domestic insurance company may, by written agreement with a custodian, provide for the custody of its securities with that custodian. The securities that are the subject of the agreement may be held by the custodian or its agent or in a clearing corporation.

(2) Any such agreement shall be in writing and shall be authorized by a resolution of the Board of Directors of the insurance company or of an authorized committee thereof. The terms of the agreement shall comply with the following:

(a) Securities' certificates held by the custodian shall be held separate from the securities certificates of the custodian and of all of its other customers.

(b) Securities held indirectly by the custodian and securities in a clearing corporation shall be separately identified on the custodian's official records as being owned by the insurance company. Said records shall identify which securities are held by the custodian or by its agent and which securities are in a clearing corporation. If the securities are in a clearing corporation, said records shall also identify where the securities are and if in a clearing corporation, the name of the clearing corporation and if through an agent, the name of the agent.

(c) All custodied securities that are registered shall be registered in the name of the company or in the name of a nominee of the company or in the name of the custodian or its nominee or, if in a clearing corporation, in the name of the clearing corporation or its nominee.

(d) Custodied securities shall be held subject to the instructions of the insurance company and shall be withdrawable upon the demand of the insurance company, except that custodied securities used to meet the deposit requirements set forth in Section 624.411, F.S., shall, to the extent required by that section, be under the control of the Office and shall not be withdrawn by the insurance company without the approval of the Office.

(e) The custodian shall be required to send or cause to be sent to the insurance company a confirmation of all transfers of custodied securities to or from the account of the insurance company. In addition, the custodian shall be required to furnish no less than monthly the insurance company with reports of holdings of custodied securities at such times and containing such information as may be reasonably requested by the insurance company. The custodian's trust committee's annual report of its review of the insurer's trust accounts shall also be provided to the insurance company. Reports and verifications may be transmitted in electronic or paper form.

(f) During the course of the custodian's regular business hours, any officer or employee of the insurance company, any independent accountant selected by the insurance company and any representative of an appropriate regulatory body shall be entitled

to examine, on the premises of the custodian, the custodian's records relating to custodied securities, but only upon furnishing the custodian with written instructions to that effect from an appropriate officer of the insurance company.

(g) The custodian and its agents shall be required to send to the insurance company all reports which they receive from a clearing corporation their respective systems of internal accounting control and reports prepared by outside auditors on the custodians or its agent's internal accounting control of custodied securities that the insurance company may reasonably request.

(h) The custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the insurance company's Annual Statement and supporting Schedules and information required in any audit of the financial statements of the insurance company.

(i) The custodian shall provide, upon written request from the Office or from an appropriate officer of the insurance company, the appropriate affidavits, on Forms OIR-A1-341 (A), (B), or (C) (rev. 12-07), or substantially similar forms with respect to custodied securities. Forms OIR-A1-341 (A), (B) and (C) (rev. 12-07), entitled "Custodian Affidavit," are hereby incorporated by reference. ~~These forms shall become effective on the effective date of these rules, and may be obtained from the Office of Insurance Regulation, Larson Building, Tallahassee, Florida~~. Forms are available at http://www.floir.com/iportal.

(j) A national bank, state bank or trust company shall secure and maintain insurance protection in an adequate amount covering the bank's or trust company's duties and activities as custodian for the insurer's assets, and shall state in the custody agreement that protection is in compliance with the requirements of the custodian's banking regulator. A broker/dealer shall secure and maintain insurance protection for each insurance company's custodied securities in excess of that provided by the Securities Investor Protection Corporation in an amount equal to or greater than the market value of each respective insurance company's custodied securities.

(k) The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft or mysterious disappearance, including loss by damage or destruction.

(l) In the event that there is a loss of custodied securities for which the custodian shall be obligated to indemnify the insurance company as provided in paragraph (2)(k) above, the custodian shall promptly replace the securities or the value thereof and the value of any loss of rights or privileges resulting from said loss of securities.

(m) The agreement may provide that the custodian will not be liable for any failure to take any action required to be taken under the agreement in the event and to the extent that the taking of such action is prevented or delayed by war (whether declared or not and including existing wars), revolution, insurrection, riot, civil commotion, act of God, accident, fire, explosion, stoppage of labor,

strikes or other differences with employees, laws, regulations, orders or other acts of any governmental authority, or any other cause whatever beyond its reasonable control.

(n) In the event that the custodian gains entry in a clearing corporation through an agent, there shall be an agreement between the custodian and the agent under which the agent shall be subject to the same liability for loss of custodied securities as the custodian, provided, however, that, if the agent shall be subject to regulation under the laws of a jurisdiction which is different from the jurisdiction the laws of which regulate the custodian, the Director may accept a standard of liability applicable to the agent which is different from the standard of liability applicable to the custodian.

(o) The custodian shall provide written notification to the Office if the custodial agreement with the insurer has been terminated or if 100% of the account assets in any one custody account have been withdrawn. This notification shall be remitted to the Office within three (3) business days of the receipt by the custodian of the insurer's written notice of termination or within three (3) business days of the withdrawal of 100% of the account assets. All filings shall be submitted electronically to http://www.floir.com/iportal.

(3)(a) Nothing in this rule shall prevent an insurance company from depositing securities with another insurance company with which the depositing insurance company is affiliated, provided that the securities are deposited pursuant to a written agreement authorized by the board of directors of the depositing insurance company or an authorized committee thereof and that the receiving insurance company is organized under the laws of one of the states of the United States of America or of the District of Columbia. If the respective states of domicile of the depositing and receiving insurance companies are not the same, the depositing insurance company shall have given notice of the deposit to the insurance commissioner in the state of its domicile and the insurance commissioner shall not have objected to it within thirty (30) days of the receipt of the notice. All filings shall be submitted electronically to http://www.floir.com/iportal.

(b) The terms of any such agreement shall comply with the following:

1. The insurance company receiving the deposit shall maintain records adequate to identify and verify the securities belonging to the depositing insurance company.

2. The receiving insurance company shall allow representatives of an appropriate regulatory body to examine records relating to securities held subject to the agreement.

3. The depositing insurance company may authorize the receiving insurance company:

a. To hold the securities of the depositing insurance company in bulk, in certificates issued in the name of the receiving insurance company or its nominee, and to commingle them with securities owned by other affiliates of the receiving insurance company; and,

b. To provide for the securities to be held by a custodian, including the custodian of securities of the receiving insurance company or in a clearing corporation.

*Rulemaking Authority 624.308(1), 628.511(1), (4), 628.535 FS. Law Implemented 624.307(1), 624.424, 625.55, 628.511 FS. History–New 2-7-85, Formerly 4-66.02, 4-66.002, 4-143.042, Amended 5-13-08 Amended_____.*

**69O-143.046 Registration of Insurers.**

(1) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the Office by April 1, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this rule and Rule 69O-143.047, F.A.C. Any insurer which becomes subject to registration under this rule after April 1 shall register within fifteen days after it becomes subject to registration. The Office may require any authorized insurer which is a member of a holding company system which is not subject to registration under this rule to furnish a copy of the registration statement or other information filed by such insurance company with the insurance regulatory authority of domiciliary jurisdiction.

(2) All filings required by this rule shall be submitted electronically to the Office via the Regulatory Electronic Filing System, "REFS." at http://www/floir.com/iportal.

(3) Every insurer subject to registration shall file a registration statement on a Form OIR-D0-516, "Form B – Insurance Company Holding System Registration Statement," rev. 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06549. ~~Insurers may obtain the form from the Office's website, located at http://www.floir.com.~~ The form shall provide current information about:

(a) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(b) The identity and relationship of every member of the insurance holding company system;

(c) The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:

1. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

2. Purchases, sales, or exchanges of assets;

3. Transactions not in the ordinary course of business;

4. Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

5. All management and service contracts and all cost-sharing arrangements;

6. Reinsurance agreements;

7. Dividends and other distributions to shareholders; and,

8. Consolidated tax allocation agreements.

(d) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) If requested by the Office, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the Office with the most recently filed parent corporation financial statements that have been filed with the SEC;

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Office; and,

(g) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(4) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement filed on a Form OIR-A1-2116, "Form C – Summary of Changes to Registration Statement," new 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06550.

(5) No information need be disclosed on the registration statement filed pursuant to subsection (3) of this rule if such information is not material for the purposes of this rule and Rule 69O-143.047, F.A.C. Unless the Office by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans, or extensions of credit, or investments, involving one-half of 1% or less of an insurer's admitted assets as of the prior year end shall not be deemed material for purposes of this section.

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on an amended Form OIR-D0-516 within fifteen calendar days after the end of the month in which it learns of each such change or addition. The amended Form OIR-D0-516 should only address those items which are being amended, and should include at the top of the cover page "Amendment No. [insert number] to Form B for [insert year]." Notwithstanding the provisions of this paragraph, dividends and other distributions to shareholders are to be reported to the Office pursuant to Section 628.371, F.S.

(7) In addition to the registration statement required in subsection (3), each registered insurer, exept foreign insurers subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially

similar to those contained in this rule and Rule 69O-143-047, F.A.C., shall also provide on Form OIR-A1-2118, "Form F – Enterprise Risk Report," new 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06552, the information required under Section 628.801(2), F.S.

(8) The Office shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(9) The Office may require or allow two or more affiliated insurers subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statement.

(10) The Office may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) of this rule and to file all information and material required to be filed under this rule.

(11) The provisions of this rule shall not apply to any insurer, information or transaction if and to the extent that the Office by rule, regulation, or order shall exempt the same from the provisions of this rule.

(12) Any person may file with the Office a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this rule which may arise out of the insurer's relationship with such person unless and until the Office disallows such a disclaimer. A disclaimer of affiliation shall be deemed to have been granted unless the Office, within thirty (30) calendar days following the receipt of a complete disclaimer, notifies the filing party that it is disallowed.

(13) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this rule chapter.

(14) The failure to file a registration statement or any amendment thereto required by this rule within the time specified for such filing shall be a violation of this rule.

(15) The following forms are hereby adopted and incorporated by reference and are available at http://www.floir.com/iportal:

(a) Form OIR-D0-516, "Form B – Insurance Company Holding System Registration Statement," rev. 5/16; http://www.flrules.org/Gateway/reference.asp?No=Ref-06549;

(b) Form OIR-A1-2116, "Form C – Summary of Changes to Registration Statement," new 5/16; http://www.flrules.org/Gateway/reference.asp?No=Ref-06550; and,

(c) Form OIR-A1-2118, "Form F – Enterprise Risk Report," new 5/16; http://www.flrules.org/Gateway/reference.asp?No=Ref-06552.

*Rulemaking Authority 624.308, 628.801 FS. Law Implemented 624.307(1), 624.317, 624.424, 628.251, 628.461, 628.801 FS. History–New 12-16-70, Formerly 4-26.02, Amended 6-7-90, 1-30-91, Formerly 4-26.002, 4-143.046, Amended 5-31-16, Amended_____.*

**69O-143.047 Standards.**

(1) Material transactions by registered insurers with their affiliates shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Charges or fees for services performed shall be reasonable;

(c) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(d) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

(e) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs; and,

(f) For cost sharing services and management services, such agreements shall, as applicable:

1. Identify the person providing services and the nature of such services;

2. Set forth the methods to allocate costs;

3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the National Association of Insurance Commissioner's Accounting Practices and Procedures Manual as adopted in subsection 69O-137.001(4), F.A.C.;

4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

6. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;

7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;

8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

9. Include standards for termination of the agreement with and without cause;

10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the

affiliate providing services;

11. Specify that, if the insurer is placed in receivership or seized by the commissioner:

a. All of the rights of the insurer under the agreement extend to the receiver or commissioner; and,

b. All books and records will immediately be made available to the receiver or the commissioner, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request;

12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership; and,

13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding the initiation of receivership proceedings pursuant to Chapter 631, F.S., and will make them available to the receiver, for so long as the affiliate continues to be contractractually and legally obligated to receive timely payment for the cost of services rendered.

(2) For the purposes of this rule in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(a) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(b) The extent to which the insurer's business is diversified among the several lines of insurance;

(c) The number and size of risks insured in each line of business;

(d) The extent of the geographical dispersion of the insurer's insured risks;

(e) The nature and extent of the insurer's reinsurance program;

(f) The quality, diversification, and liquidity of the insurer's investment portfolio;

(g) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(h) The surplus as regards policyholders maintained by other comparable insurers;

(i) The adequacy of the insurer's reserves; and,

(j) The quality and liquidity of investments in subsidiaries made pursuant to Section 625.325, F.S.

The Office may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in its judgment such investment so warrants.

(3) No domestic stock insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(a) 30 calendar days after the Office has received notice of the declaration thereof and has not within such period disapproved such payment; or

(b) The Office shall have approved such payment within such 30 calendar day period.

A notice to the Office shall commence to run from the date of receipt as may be evidence by transmitting electronically to the Office via, Regulatory Electronic Filing System, "REFS," return receipt if sent certified or registered mail, return receipt requested or signed receipt by Office if otherwise delivered.

For purposes of this rule, an extraordinary dividend or distribution includes any dividend or distribution that is in excess of that permitted without the approval of the Office pursuant to Section 628.371, F.S., but shall not include prorata distributions of any class of the insurer's own securities.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the Office's approval thereof, and such a declaration shall confer no rights upon shareholders until the Office has approved the payment of such dividend or distribution.

(4) The following transactions involving a domestic insurer and any person in its holding company system may not be entered into unless the insurer has notified the Office, via Form OIR-A1-2117, "Form D – Prior Notice of a Transaction," new 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06551, which is hereby adopted and incorporated by reference, and is available at www.floir.com/iportal, of its intention to enter into such a transaction at least thirty (30) calendar days prior thereto, or such shorter period as the Office in its discretion may permit, and the Office has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the insurer.

(a) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments provided such transactions are equal to or exceed:

1. With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders; and,

2. With respect to life insurers, three percent of the insurer's admitted assets; each as of the prior year end.

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit provided such transactions are equal to or exceed:

1. With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders; and,

2. With respect to life insurers, three percent of the insurer's admitted assets; each as of the prior year end.

(c) Reinsurance agreements or modifications thereto, including:

1. All reinsurance pooling agreements;

2. Agreements in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five percent of the insurer's surplus as regards policyholders, as of the prior year end, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements and all cost-sharing arrangements; and,

(e) Any material transactions which the Office determines may adversely affect the interests of the insurer's policyholders.

(5) The filing required in subsection (4), above, shall be filed with the Office electronically via the Regulatory Electronic Filing System ("REFS").

(6) Nothing in subsection (4), above, shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to Florida statute or rule.

(7) A domestic insurer shall not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review which would otherwise occur. If the Office determines that such separate transactions were entered into over any twelve month period for such purpose, the insurer may be subject to the provisions of Section 628.803, F.S.

(8) The Office, in reviewing transactions pursuant to subsection (4), above, shall consider whether the transactions comply with the standards set forth in subsection (1), above, and whether they may adversely affect the interests of policyholders.

(9) The Office shall be notified within thirty (30) calendar days of any investment of the domestic insurer in any one corporation if the total investment in such corporation by the insurance holding company system exceeds ten percent of such corporation's voting securities.

(10) All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking Authority 624.308, 628.801 FS. Law Implemented 624.317, 624.424, 628.251, 628.371, 628.381, 628.461, 628.801, 628.803, 624.307(1) FS. History–New 12-16-70, Formerly 4-26.03, Amended 1-30-91, Formerly 4-26.003, 4-143.047, Amended 5-31-16 Amended_____.*

**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 Sections 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 Sections 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.

(b) "Certified reinsurer" means an assuming insurer that may not meet the requirements of Sections 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.

(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 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 (e) 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., the rating agencies are:

(a) Standard and Poor's;

(b) Moody's Investors Service;

(c) Fitch Ratings;

(d) A.M. Best Company; and,

(e) Demotech.

(4) The collateral required to allow one hundred percent (100%) credit shall be no less than the percentage specified for the lowest rating as indicated below:

| Rating | Collateral Required | Best | S&P | Moody's | Fitch | Demotech |
|---|---|---|---|---|---|---|
| Secure – 1 | 0% | A++ | AAA | Aaa | AAA | A" |

| | | | | | | |
|---|---|---|---|---|---|---|
| Secure – 2 | 10% | A+ | AA+, AA, AA- | Aa1, Aa2, Aa3 | AA+, AA, AA- | A' |
| Secure – 3 | 20% | A | A+, A | A1, A2 | A+, A | A |
| Secure – 4 | 50% | A- | A- | A3 | A- | n/a |
| Secure – 5 | 75% | B++, B+ | BBB+, BBB, BBB- | Baa1, Baa2, Baa3 | BBB+, BBB, BBB- | n/a |
| Vulnerable – 6 | 100% | B, B-, C++, C+, C, C-, D, E, F | BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R | Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C | BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD | n/a |

For reinsurance ceded by Florida domestic property insurers for short-tailed lines as defined below, any collateral required to be posted may be subject to a one-year deferral from the date of the first instance of a liability reserve entry as a result of a catastrophic loss from a named Hurricane. For these purposes, a short-tailed line of business is defined as any one of the following lines of business as reported on the NAIC annual financial statement:

Line 1 Fire

Line 2 Allied Lines

Line 3 Farmowners multiple peril

Line 4 Homeowners multiple peril

Line 5 Commercial multiple peril

Line 9 Inland marine

Line 12 Earthquake

Line 21 Auto physical damage

(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(4), F.S.

(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(5)(b), F.S., for the payment of the valid claims of its U.S. cedent insurers and their assigns and successors in interest to also maintain in a qualified U.S. financial institution a trust fund constituting a trusteed amount at least equal to the collateral required in accordance with subsection (4) of this

rule to secure the liabilities attributable to U.S. 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 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 an certified reinsurer, pursuant to subsection (8) of this rule;

(b) The ceding insurer maintains satisfactory evidence that the eligible certified 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:

1. For an insolvency clause in conformance with Section 624.610(8), F.S.;

2. For a service of process clause in conformance with Sections 624.610(3)(f)1. and 2., F.S.; and,

3. 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) 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.floir.com/iportal. The cover letter shall be accompanied with the following:

1. Audited financial statements prepared on a U.S. GAAP 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) Upon receipt of an application for a determination as a certified reinsurer, the Office shall post notice on the Office's website. Such notice shall include instructions on how members of the public may respond to the application. The Office shall not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

(c) The determination of eligibility will be made by order issued by the Office.

(d) To become a certified reinsurer, the insurer, at a minimum:

1. Shall hold surplus in excess of $250 million. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250 million and a central fund containing a balance of at least $250 million;

2. Shall be authorized in its domiciliary jurisdiction to assume the kind or kinds of reinsurance ceded by the ceding insurer; and,

3. Shall be domiciled in a qualified jurisdiction as defined in subsection (9).

(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 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. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

3. For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

4. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

5. Regulatory actions against the certified reinsurer;

6. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding; and,

7. A certified reinsurer's participation in any solvent schemes of arrangement, or similar procedure, that involves U.S. ceding insurers. A certified reinsurer shall notify the Office prior to participation in a solvent scheme of arrangement.

(f) If the Office determines, based upon the material submitted, and any other relevant information, that it is in the best interests of market stability and the solvency of ceding insurers, the Office will find, by order, that the insurer is a certified reinsurer and will set an amount of credit allowed for the reinsurer if lower than the amount set forth in subsection (4).

(g) The Office shall publish and maintain a list of certified reinsurers on the Office's website. Such list shall disclose the rating assigned to the certified reinsurer pursuant to subsection (4) of this rule.

(h) Every certified reinsurer shall file the following information annually with the Office electronically via the Office's Regulatory Electronic Filing System, "REFS," located at http://www.floir.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) A certified reinsurer must advise the Office within ten (10) days of any changes in its ratings assigned by rating agencies, domiciliary license status, or of any regulatory actions taken against the certified reinsurer. Such notice shall include a statement describing such actions and the reasons therefore.

(j) At any time, if the Office determines that it is in the best interests of market stability and the solvency of ceding insurers, the Office will withdraw, by order, any determination of an insurer as a certified reinsurer or require the certified reinsurer to post additional collateral.

(k) If the rating of a certified reinsurer rises above that used by the Office in its determination of the credit allowed for the reinsurer, an affected party may petition the Office for a redetermination of the credit allowed. If it is in the best interests of market stability and the solvency of ceding insurers, the Office will raise the credit allowed for the certified reinsurer.

(9) Status as a qualified jurisdiction:

(a) The determination of a jurisdiction as a qualified jurisdiction is to be made by the Office. No jurisdiction shall be determined to be a qualified jurisdiction unless:

1. The insurance regulatory body of the jurisdiction agrees that it will provide information requested by the Office regarding its certified domestic reinsurers;

2. The Office has determined that the jurisdiction has a satisfactory structure and authority with regard to solvency regulation, acceptable financial and operating standards for reinsurers in the domiciliary jurisdiction, acceptable transparent financial reports

filed in accordance with generally accepted accounting principles, and verifiable evidence of adequate and prompt enforcement of valid U.S. judgments or arbitration awards;

3. The Office has determined that the history of performance by reinsurers in the jurisdiction is such that the insuring public will be served by a finding of qualification;

4. For non-U.S. jurisdictions, the jurisdiction allows U.S. reinsurers access to the market of the domiciliary jurisdiction on terms and conditions that are at least as favorable as those provided in Florida law and regulations for unaccredited non-U.S. assuming insurers; and,

5. There is no other documented information that it would not serve the best interests of the insuring public and the solvency of ceding insurers to make a finding of qualification.

(b) If the NAIC issues findings that certain jurisdictions should be considered qualified jurisdictions, the Office shall, if it would serve the best interests of the insuring public and the solvency of ceding insurers, make a determination that jurisdictions on the NAIC list are qualified jurisdictions.

(c) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as a qualified jurisdiction.

(d) The Office shall publish a list a jurisdictions that have been determined to be qualified.

(e) If the Office determines that it is in the best interests of market stability and the solvency of ceding insurers, the Office shall withdraw, by order, the determination of a jurisdiction as a qualified jurisdiction.

(10)(a) If the rating of a certified reinsurer is below or falls below that required in subsection (4) 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) If the ceding insurer's experience in collecting recoverables from any certified reinsurer indicates that the credit to the ceding insurer should be lower, the ceding insurer shall notify the Office of this.

(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 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) If the rating of a certified reinsurer is upgraded by the Office, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the Office shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Office, the Office shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(e) Upon revocation of the certification of a certified reinsurer by the Office, the assuming insurer shall be required to post security in accordance with Section 624.610, F.S., in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer.

(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) That obligations of a certified reinsurer for which credit for reinsurance was taken under this rule are more than ninety (90) days past due and not in dispute; or

(b) That there is any indication or evidence that any certified reinsurer, with whom the ceding insurer has a contract, fails to substantially comply with the solvency requirements under the laws of its domiciliary jurisdiction.

(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.

(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) If a certified reinsurer fails to comply on a timely basis with paragraph (a) of this subsection, the Office shall withdraw the reinsurer's certification under this rule.

(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.

(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. ~~Forms adopted in this rule are available on the Office's web site located at http://www.floir.com.~~

*Rulemaking Authority 624.308, 624.610(14) FS. Law Implemented 624.307(1), 624.424, 624.610 FS. History–New 10-29-08, Amended 7-28-15 Amended* _____.

**69O-167.012 Certificates of Security for Hurricane Deductibles.**

(1) The purpose of this rule is to specify the form for a Certificate of Security to be used pursuant to Section 627.701(5), F.S.

(2)(a) An insurer that elects to offer a policy with a secured hurricane deductible on a personal lines property insurance policy shall require the insured to provide a Certificate of Security or a verification that the insured has a 100% equity interest in the property to be insured.

(b) An insurer may not directly or indirectly require a secured hurricane deductible as a condition of issuing or renewing a policy.

(3) An insurer shall accept a Certificate of Security only when it uses form OIR-A1-1203 (8/96), Certificate of Security, which is hereby adopted and incorporated by reference. Form OIR-A1-1203 may be obtained from the Office's web site at http://www.floir.com/iportal. ~~Bureau of Property and Casualty Solvency, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, Florida 32399-0329.~~

*Rulemaking Authority 627.701(6)~~(5)~~ FS. Law Implemented 624.424, 627.701(6)~~(5)~~ FS. History–New 4-29-97, Formerly 4-167.012 Amended_____.*

# CERTIFICATE OF SECURITY

Issued by _____ to _____
Insured

The policy#_____provided _____ by _____
Insured Insurer

to provides for the following deductibles:

(a) Coverage afforded for each claim is subject to an initial deductible of $500 which is applicable to all perils.

(b) As to hurricane losses only, after satisfying the deductible in (a), the next $5,000 in losses for each claim is fully insured subject to a maximum copayment requirement of 10%.

(c) As to hurricane losses only, after satisfying the deductibles in (a) and (b), only the remainder of any claim which exceeds the losses in (a) and (b) is subject to a deductible equal to___ % of the policy limits in excess of the deductible amounts. The maximum amount for a deductible for (c) is 10% of the policy dwelling limits. The insurer must agree to renew the coverage on a guaranteed basis after initial issuance of the secured deductible for at least 1year for each 2 percentage points of deductible specified in (c).

**This Certificate of Security is issued on the following basis [check one]:**

[ ] Issuer is a Florida licensed agent, mortgage lender, or other financial institution as defined in Section 655.005, Florida Statutes, or the financial consortium prescribed in Section 627.701(6)(d)2., Florida Statutes, or has issued a line of credit which may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.

[ ] Issuer is a person qualified to act as a trustee and has secured a pledge of assets which may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.

[ ] Issuer is an authorized insurer or eligible surplus lines insurer and has issued a policy of supplemental insurance only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.

[ ] The Office has approved an alternate method in accordance with Section 627.701(6)(d)5., Florida Statutes. A copy of the approval is attached.

The above information is true and correct to the best of my knowledge.

_____ Date /____/__
(Insured)

_____ Date /____/__
(for: Florida Licensed Agent / Mortgage Lender / Financial Institution / Insurer / or Trustee)

_____
(Type or print name of: Florida Licensed Agent/ Mortgage Lender/ Financial Institution/ Insurer/ or Trustee)

**69O-170.030 Loss Reserve Discounts.**

(1) No insurer shall apply a discount to its loss reserves other than tabular workers' compensation loss reserves without special permission from the Office. An insurer shall request such special permission in writing, stating the line of insurance to be discounted and the rate of discount to be applied. Any insurer wishing to discount its December 31 reserves shall apply to the Office for special permission no later than December 1. All filings shall be submitted electronically to http://www.floir.com/iportal.

(2) For workers' compensation, an insurer may discount only its tabular loss reserves and the interest rate used to calculate the reserve discount shall be no more than 4%, unless the Office grants special permission for a higher discount rate.

(3) Any reserve discounting shall be shown in Schedule P of the insurer's annual statement. The insurer shall also show both discounted and undiscounted reserves.

(4) If the Office grants special permission to discount reserves, an actuarial report supporting the amount of discount shall be maintained by the insurer and shall be available to the Office on request. The report shall show the calculation of the discount and the payment patterns used to support the discount. The payment patterns supporting the discount shall be derived from appropriate company data, or, if company data is not credible, from appropriate industry data (for example, industry Schedule P data), and the report shall provide appropriate explanations and support with the selected payment patterns.

(5) Allocated and unallocated loss expense reserves are not to be discounted without special permission from the Department.

(6) Upon receipt of permission to discount its reserves, the insurer shall compute the excess of the statutory minimum reserves over statement reserves using the discounted loss and loss expense reserves rather than the undiscounted reserves.

*Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 625.091 FS. History–New 1-27-92, Formerly 4-170.030 Amended_____.*

**69O-187.006 Deficit Assessments and Surplus Funds.**

(1) In the event of a deficit in any fund year, such deficit shall be made up, either from unencumbered surplus from a fund year or years other than the current fund year; or, upon approval by the Office, by assessment of the membership, if necessary and consistent with sound actuarial principles, or by such alternate method as the Office may approve. The Office shall be notified prior to any transfer of unencumbered surplus funds.

(2) If necessary and consistent with sound actuarial principles, the Fund may issue dividends or refunds to its members as approved by the Office.

(3) All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 627.357(6), 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.357 FS. History–New 10-7-75, Formerly 4-39.05, Amended 5-10-89, Formerly 4-39.005, 4-187.006, Amended_____.*

**69O-187.007 Continuing Requirements Including Filing of Reports and Rates.**

(1) The Trustees shall have the accounts and records of the Fund audited annually or at any time as may be required by the Office, such audit to be made by Certified Public Accountants or by authorized representatives of the Office, with the Office reserving the right to prescribe a uniform accounting system to be used by the Fund in order that it may determine the solvency of the Fund. An audit prepared by other than Office personnel shall be a certified audit filed with and received by the Office in Tallahassee within ninety (90) days after the close of the fund year. All filings shall be submitted electronically to http://www.floir.com/iportal.

(2) The Trustees shall annually file a report as to financial condition, loss experience, and operational expense of the Fund on Form OIR-342 entitled "Medical Malpractice Self-Insurance Trust Fund Annual Audit". This report shall be due and must be received by the Office within ninety (90) days of the close of the fund year. Form OIR-342, rev. 2/93, is hereby adopted and incorporated by reference. Forms are available at http://www.floir.com/iportal. ~~Form OIR-342 may be obtained from and shall be submitted to the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Rates, Larson Building, Tallahassee, Florida 32399-0300.~~

(3) The Fund and its Service Agent shall be subject to Office inspection and examination of the affairs, transactions, accounts, books, records, and assets of the self-insurance trust fund or Service Agent as often as the Office deems advisable. The reasonable expense of any such examination including record reconstruction or costs of appraisals shall be borne by the Fund but for no more than one examination per year.

(4) Each Fund shall comply with Section 627.912, Florida Statutes, and Rule 69O-171.003, F.A.C., by filing Form DI4-303 entitled "Florida Medical Professional Liability Insurance Claims Report" with the Office. Form OIR-303 may be obtained from the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Rates, Larson Building, Tallahassee, Florida 32399-0300.

(5) The Trustees and the Service Agent shall make available to the Office at their request any or all minutes pertaining to the meetings of the Trustees. Any matter relating to individual members or individual claims may be edited to preserve the confidentiality of the member's name or claim information.

(6) The Fund shall file with the Office all changes or modifications to documents previously filed with the Office at least thirty (30) days prior to the date of implementation and all changes and modifications shall be subject to Office approval. All filings shall be sumbitted electronically to http://www.floir.com/iportal.

(7) The Fund shall file all rate changes with the Office at least thirty (30) days prior to use and include in such filings the

expense factors underlying the proposed rates and such additional information that demonstrates that rates are adequate so as to guarantee the maintenance of sufficient reserves to cover contingent liabilities. The Office's responsibility in the review of such filings shall be as follows:

(a) At such time the Office determines the expense factors are justified, and the associated rates are adequate so as to guarantee the maintenance of sufficient reserves to cover contingent liabilities, the Fund shall be notified in writing that the expense factors are approved and the rates utilizing such expense factors are acceptable for use.

(b) The Office shall disapprove any rate if it is determined that the expense factors are not justified and reasonable or that the rates are inadequate and do not guarantee the maintenance of sufficient reserves to cover contingent liabilities. The Fund shall be notified by certified mail of this fact with an explanation of the underlying factors that led to such conclusion. The Fund shall be entitled to the rights as specified in Chapter 120, Florida Statutes. In the event the filing is deficient and the Office cannot make an initial determination, the Office shall within thirty (30) days of the receipt of such filing request in writing additional information. The Fund shall have thirty (30) days from the date of the Department's request to respond, and if such information is not received or is not sufficiently responsive, the rates shall be disapproved. The Fund shall be entitled to the rights as specified in Chapter 120, Florida Statutes.

(8) Unless otherwise indicated in these rules, all Funds shall maintain on a continuing basis and file with the Office the requirements pursuant to paragraphs 69O-187.004(2)(a), (d), (e) and (g) through (p), F.A.C. Failure to do so may result in withdrawal of the Fund's self-insurance privilege.

(9) The Trustees shall file quarterly reports as to the financial condition, loss experience and operational expense of the Fund on Form OIR-343, "Medical Malpractice Self-Insurance Trust Fund Quarterly Audit", rev. 2/93, which is hereby adopted and incorporated by reference. This report is due and must be received by the Office within sixty (60) days of the close of the fund quarter. Forms are available at http://www.floir.com/iportal. ~~Form OIR-343 may be obtained from and shall be submitted to the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Rates, Larson Building, Tallahassee, FL 32399-0300.~~

(10) Each Fund shall comply with Sections 627.4147 and 627.4148, Florida Statutes.

*Rulemaking ~~Specific~~ Authority 624.308(1), 627.357(6) FS. Law Implemented 624.307(1), 624.424, 627.357, 627.4147, 627.4148 FS. History–New 10-7-75, Formerly 4-39.06, Amended 5-10-89, Formerly 4-39.006, Amended 1-18-94, Formerly 4-187.007, Amended_____.*

**69O-187.008 Contracts for Excess Insurance.**

Specific excess and aggregate excess insurance may be required as a condition of approval or continuing operation of the Fund. The Fund shall not voluntarily reduce its specific excess or aggregate excess insurance without the prior approval of the Office. The Fund shall notify the Office of any involuntary changes in such coverages as soon as the Fund receives notice of any such change in coverage. The Office may approve the continued operations of the Fund with the reduced coverage taking into consideration the availability of such excess insurance, the financial condition of the Fund and the cost of any such excess insurance. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 627.357(3), 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.357 FS. History–New 10-7-75, Formerly 4-39.07, Amended 5-10-89, Formerly 4-39.007, 4-187.008, Amended_____.*

**69O-187.009 Termination or Merger of Self-Insurance Trust Fund.**

(1) The Trustees of the Fund shall oversee and approve the voluntary termination or voluntary merger of the Fund in accordance with Section 627.357(7)(i), Florida Statutes. The Service Agent shall cooperate and provide the necessary assistance required to effectuate such termination or merger.

(2) For a voluntary termination or voluntary merger of the Fund, the Trustees shall:

(a) Provide the Office with written notification of the Fund's intent to terminate or merge but only with the consent of a two-thirds vote of the Trustees and of the members.

(b) Provide the Office with minutes of the Trustees' meeting approving the termination or merger.

(c) Submit to the Office a detailed plan to handle the termination or merger. Such plan shall be subject to the approval of the Department and shall include the following:

1. Evidence of adequate disclosure to affected parties including the members and the Trustees of the contemplated termination or merger. Transactions involving affiliates, representatives or interested parties shall be fully disclosed to the members and Trustees, and shall include evidence that said transactions are in the best interest of the Fund. Furthermore, the Office shall require the Trustees to seek independent legal and actuarial counsel regarding the actions taken in contemplation of the termination or merger, to certify the adequacy of all disclosures made and the sufficiency of all due diligence conducted on behalf of the members or the Trustees, in order to assist the Office in determining actuarial soundness. Parties providing such counsel shall not be employed with or in any way affiliated with the assuming insurer.

2. For a termination:

a. The Fund shall continue in a run-off mode, which is a common insurance industry term which means that assets are not released until the last claim has been fully settled. The Fund shall have a reserve analysis completed on its existing liabilities by an actuary who is a member of the Casualty Actuarial Society. The Fund shall maintain compliance with Section 627.357, Florida Statutes, and the applicable provisions of this Part, including the continued service of the Trustees and the administration of the Fund by the Service Agent.

b. The Office shall exempt the Fund from the requirements of sub-subparagraph a., if the Fund demonstrates that the purchase through competitive bidding of an appropriate insurance product relieving the Fund of any liabilities incurred while operating pursuant to Section 627.357, Florida Statutes, is in the best interest of the Fund and that the provider of the product is an insurer authorized to transact insurance in this state.

c. Any monies remaining in the Fund after the satisfaction of all liabilities incurred while operating pursuant to Section 627.357,

Florida Statutes, shall be declared dividends and returned to the members of the Fund.

3. For a merger:

a. The Fund shall submit a request for a Loss Portfolio Transfer All filings shall be submitted electronically to http://www.floir.com/iportal. ~~on Form OIR-LPT, "Medical Malpractice Self-Insurance Trust Fund Application for Loss Portfolio Transfer," rev. 7/93, which is hereby adopted and incorporated by reference. The form may be obtained from and shall be submitted to the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0300.~~

b. The Fund shall have a reserve analysis completed on its existing liabilities by an independent actuary who is a member of the Casualty Actuarial Society. The liabilities of the Fund as determined in the reserve analysis shall be assumed, as evidenced in the Loss Portfolio Transfer Agreement, by an insurer authorized to transact insurance in this state. The assuming insurer shall provide a three-year pro-forma on both a countrywide and Florida only basis indicating the projected impact of the contemplated assumption of the Fund's liabilities. Furthermore, a three-year business plan shall be provided if the assuming insurer plans to or is currently writing medical malpractice insurance. Rates for any assuming insurer planning to or currently writing medical malpractice insurance shall be actuarially sound and in compliance with Section 627.062(1), Florida Statutes. The most recent Annual Statement of the assuming insurer shall contain the appropriate loss reserve certification, as required by Section 624.424, Florida Statutes and Rule 69O-137.001, F.A.C.

c. The Office shall require a portion of the LPT assets deemed to be material in accordance with the application of generally accepted accounting practices and procedures to be placed in an interest bearing trust account designated by the Treasurer of this state and maintained for the purpose of holding such deposits. Such deposit is to be maintained as assurance of the payment of claims arising from policies issued by the Fund; provided, that the interest shall be credited to the assuming insurer and reported to the assuming insurer's taxpayer ID number and that the assuming insurer may take financial statement credit for this deposit. Such deposit shall remain in place for a period of 5 years; provided, that the assuming insurer may apply for release of all or part of the deposit prior to the end of the 5 year period. The Office shall release the deposit if the insurer demonstrates that the interests of the Fund members are otherwise protected. The assuming insurer shall not, without the express consent of the Office, for a period of 5 years, pay any dividend to its shareholders or permit the ratio of its premiums to surplus and capital to exceed 3:1. If the assuming insurer seeks the Office's consent to grant a dividend or increase its writing to surplus ratio, the Department shall grant such a request if the insurer demonstrates that the interests of the Fund members are otherwise protected. In the event the assuming insurer's claims payments for the liabilities of the Fund, including ALAE and ULAE, are less than that projected in the reserve

indication set forth in the material presented to the members at the time of the merger, the difference between the projected amount and the amount actually paid shall be refunded back to the Fund members.

(3) A termination or merger of the Fund initiated by the Office shall be in accordance with the provisions of Section 627.357(7)(i), Florida Statutes.

*Rulemaking ~~Specific~~ Authority 624.308(1), 627.357(6) FS. Law Implemented 624.307(1), 624.424(6), 627.357 FS. History–New 1-18-94, Formerly 4-187.009 Amended_____.*

**69O-188.022 Filing of the Commercial Self-Insurance Fund Experience Reporting Form.**

(1) On or before March 31 of each year or a later date if approved by the Office ~~Department~~ for good cause, each commercial self insurance fund shall complete for the preceding policy years, excluding closed policy years, evaluated as of the preceding December 31, and submit to the Office ~~Department~~ Form OIR-EX, "Commercial Self-Insurance Fund Experience Reporting Form," rev. 8/90, and Form OIR-IA, "Commercial Self-Insurance Fund Policy Year Investment Income Allocation Schedule (Schedule "A")," rev. 8/90, in accordance with this rule. Forms OIR-EX and OIR-IA, and the accompanying instructions are hereby adopted and incorporated by reference. Forms are available at http://www.floir.com/iportal. ~~Copies of Forms OIR-EX and OIR-IA may be obtained from the Office of Insurance Regulation, Bureau of Property and Casualty Insurer Solvency, Larson Building, Tallahassee, Florida 32399-0300.~~

(2) Each fund shall, upon filing its initial Form OIR-EX and Form OIR-IA, elect to report on either a policy year or calendar-accident year basis. Thereafter, the reporting shall be on a consistent basis from year to year. Any changes in accounting or actuarial technique used in developing data shall be approved by the Office ~~Department~~. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.470, 624.474, 624.488 FS. History–New 12-17-90, Formerly 4-78.022, 4-188.022 Amended_____.*

**69O-188.023 Filing of the Annual Statement by Commercial Self-Insurance Funds.**

(1) Each commercial self-insurance fund shall submit electronically to http://www.floir.com/iportal. ~~comply with Rule Chapter 69O-137, F.A.C., Insurer Annual Statement Diskette Filing Specifications.~~ For the purpose of complying with Rule Chapter 69O-137, F.A.C., a commercial self-insurance fund shall be considered an authorized insurer, except that the fund's annual statement shall be due on or before April 1 of each year.

(2) As an aggregate write-in on the balance sheet of the Annual Statement for assets and policyholders' surplus, an entry for future investment income on losses and allocated loss adjustment expense reserves and unallocated loss adjustment expense reserves shall be reflected. Future investment income shall be calculated as follows:

A + B + C - D

A = Losses and Allocated Loss Adjustment Expense Reserves

B = Unallocated Loss Adjustment Expense Reserves

C = Excess of Statutory Reserves over Statement Reserves

D = Present Value of A + B + C

(3) If a commercial self-insurance fund elects to report on a policy year basis under Rule 69O-188.022, F.A.C., then the commercial self-insurance fund shall file a supplemental schedule on a policy year basis of Schedule P of the NAIC Annual Statement Form for Fire and Casualty Insurers.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.470, 624.474, 624.488 FS. History–New 12-17-90, Formerly 4-78.023, 4-188.023 Amended_____.*

**69O-188.024 Deficiency/Assessment Procedure.**

(1) After four (4) completed policy years, the commercial self-insurance fund trustees shall, within sixty (60) days of filing Forms OIR-EX and OIR-IA with the Office, make up any deficiencies identified in each policy year on Form OIR-EX, line 13., or shall levy an assessment upon the members for the amount needed to make up said deficiencies.

(2) Prior to a fund reporting four (4) complete policy years, the Office shall order the trustees of a fund to make up a deficiency or assess its members who participated in a policy year in which a deficiency is reported unless the fund can present an actuarially sound plan to amortize the deficiency. The Office may require that such plan be certified by an actuary who is a member of the American Academy of Actuaries.

(3) If needed, the trustees shall levy an assessment by sending a notice of assessment by certified mail to the address of record of each member of the fund from whom an assessment is due. The trustees shall take all steps necessary and reasonable to collect the assessment as soon as is reasonably possible. The trustees shall not be required to pursue assessments against a member if to do so would not be cost-effective.

(4) The fund may petition the Office within thirty (30) days of filing Forms OIR-EX and OIR-IA, to delay levying an assessment if it believes to do so is prudent. The Office shall grant the petition if the fund demonstrates to the satisfaction of the Office that the deficiency indicated on Form OIR-EX is likely to be resolved without an assessment. While such petition is under consideration by the Office, the sixty (60) day requirement in subsection 69O-188.024(1), F.A.C., shall not be applicable. However, if such petition is denied by the Office, the fund shall levy the assessment within sixty (60) days of such denial. All forms shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.470, 624.474, 624.488 FS. History–New 12-17-90, Formerly 4-78.024, 4-188.024 Amended_____.*

**69O-196.005 Filing Surety Bond in Lieu of Net Worth.**

(1) A surety bond in the amount of $35,000.00 may be filed with the Office ~~department~~ by premium finance companies in conjunction with a $10,000 minimum net worth; and all filings shall be submitted electronically to http://www.floir.com/iportal.

(2) Such surety bond must be written by an insurer authorized to do business in this state; and

(3) Such surety bond shall be approved by the office and shall not be cancelled without a thirty-day written notice to the department.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 627.828 FS. History–New 10-20-73, Repromulgated 12-24-74, Formerly 4-18.05, 4-18.005, Amended 8-29-99, Formerly 4-196.005 Amended_____.*

**69O-196.007 Annual Reports.**

(1) The annual report shall be filed on or before March 1 of each year. The due date is the date by which the report is to be RECEIVED in the Office, NOT THE POSTMARK DATE.

(2) The annual report shall be filed on form OIR-A3-107(11/97), Annual Report, which is incorporated by reference in Rule 69O-196.015, F.A.C. Each page of the form shall be completed and prepared according to the instructions. An incomplete form shall be returned and considered not filed by the Office. Failure to file a complete annual report by the due date shall subject a licensee to fines as set forth in Rule 69O-207.007, F.A.C., and discipline as provided in Sections 627.832 and 627.833, F.S. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 627.836 FS. History–New 10-20-73, Repromulgated 12-24-74, Formerly 4-18.07, 4-18.007, Amended 7-27-95, 8-29-99, Formerly 4-196.007 Amended_____.*

**69O-196.009 Other Reports and Corrective Action Plans.**

To aid the Office in determining a licensee's continued eligibility to hold a premium finance license:

(1) If the Office has reason to believe that the owners, officers, or directors of the premium finance company or any parent or controlling company, if any, have been involved in activity which has been shown to be hazardous to the insurance-buying public in this or any other state, the Office shall require all owners of 10% or more of the company's stock, and all officers and directors, to update the biographical information on file with the Office.

(2) Changes in senior corporate officers, chief executive officer, chief financial officer, or directors (or members of a properly authorized and appointed executive committee thereof), or if the licensee is not incorporated, changes in management personnel who have decision or policy-making authority over the premium finance company, shall be reported in writing to the Office within 60 days after the effective date of the change. Such changes will require completion of biographical information in the form required by the Office and an independent investigative background report of the person or entity, plus an investigation fee. All filings shall be submitted electronically to http://www.floir.com/iportal.

(3) Every premium finance company is subject to the provisions of Section 628.4615, F.S. Each application for acquisition of an authorized premium finance company is subject to a license fee and an investigation fee.

(4) Whenever the financial condition of the premium finance company is such that administrative supervision is appropriate based on the standards set forth in Rule 69O-141.002, F.A.C., the Office shall order the premium finance company to file with the Office and implement a corrective action plan designed to do one or more of the following:

(a) Reduce the total amount of present liability by assignment of contracts or other means.

(b) Reduce the expenses of the premium finance company by methods specified in the corrective plan, subject to the standards set forth in Rule 69O-141.003, F.A.C.

(c) Suspend or limit the writing of new business for a period of time necessary to protect the public from the hazardous financial condition of the premium finance company.

(d) Require an increase in the premium finance company's net worth sufficient to bring the company into compliance with Section 627.828, F.S. If the premium finance company fails to submit a plan within 30 days of the Office's order or submits a plan which is insufficient to correct the premium finance company's financial condition, the Office shall order the premium finance company to implement one or more of the corrective actions listed in this subsection.

(5) If the Office determines that a company is insolvent, the Office shall notify the company of such insolvency. If the company disagrees with the Office's determination, it shall within 15 calendar days file with the Office all information that proves that the

company is not insolvent.

(6) If the company fails within the 15-day period provided in subsection (5) to supply information showing to the satisfaction of the Office that the company is not insolvent, the Office shall:

(a) Instruct the company to suspend acquisition of any new business if acquisition of new business would place the public at substantial risk;

(b) Suspend or revoke the company's certificate of authority if administrative supervision is not viable due to the severity of the company's condition or the company's unwillingness to cooperate with the Office in the development and implementation of a corrective plan; or

(c) Place the company in administrative supervision under Section 624.81, F.S., subject to the limitations imposed by that section.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.80, 624.81, 627.828, 627.829, 627.832, 627.834, 627.836, 627.849, 628.4615 FS. History–New 7-27-95, Formerly 4-196.009 Amended_____.*

**69O-196.015 Forms Incorporated by Reference.**

The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 627, Part XV, F.S.:

| Title | Form Number |
|---|---|
| (1) Application for License to Conduct Business in the State of Florida as a Premium Finance Company | OIR-99 (10/94) |
| (a) Application for Certificate of Authority Premium Finance Company | OIR-979 (10/94) |
| (b) Instructions for Application | OIR-958 (6/95) |
| (c) Checklist for Application | OIR-972 (6/95) |
| (d) Request for Payment of Application Fees | OIR-971 (10/94) |
| (e) Management Information Form | OIR-844 (10/91) |
| (f) Listing of Stockholders | OIR-973 (10/91) |
| (g) Instructions for Statutory Compliance of Forms | OIR-957 (6/95) |
| (2) Annual Report | OIR-107 (11/97) |
| (3) Bond | OIR-453 (6/95) |
| (4) Authority to Release Information | OIR-450 (6/95) |
| (5) Biographical Statement and Affidavit | OIR-422 (11/90) |
| (6) Personal Financial Statement | OIR-454 (5/89) |
| (7) Fingerprint Card Instructions | OIR-938 (4/91) |
| (8) Request for Payment of Fingerprint Charges | OIR-903 (1/94) |
| (9) Instructions for Furnishing Background Investigation Reports | OIR-905 (9/94) |
| (10) Application for Acquisition of a Premium Finance Company | OIR-448 (12/91) |
| (a) Consent and Agreement in Re Service of Process | OIR-144 (11/90) |
| (b) Resolution Form | OIR-514 (11/90) |
| (11) Statement of Account | OIR-970 (10/91) |

These forms shall become effective on the date this rule becomes effective. Forms are available at http://www.floir.com/iportal. ~~Copies of the forms may be obtained from the Office of Insurance Regulation, Bureau of Specialty Insurers, Larson Building, Tallahassee, FL 32399-0331.~~

*Rulemaking* ~~*Specific*~~ *Authority 624.308 FS. Law Implemented 624.321(1)(a), 624.424, 627.828, 627.829, 627.836, 627.845,*

*628.4615 FS. History–New 5-28-90, Formerly 4-18.015, Amended 7-27-95, 8-29-99, Formerly 4-196.015 Amended_____.*

**69O-196.021 Disclosure Requirements for Insurance Coverages Financed With Personal Injury Protection.**

(1) Whenever motor vehicle insurance is financed, the agent shall disclose at the time of sale any coverages financed with personal injury protection other than property damage liability, bodily injury, collision, uninsured motorist, or comprehensive coverage for damage of or loss to the vehicle.

(2) The disclosure shall be on Form OIR-1162 (3/95), which is incorporated herein by reference. Forms are available at http://floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal. ~~A blank form can be obtained from the Bureau of Specialty Insurers, 200 East Gaines Street, Tallahassee, Florida 32399-0331, from which you may make as many copies as needed. Photocopies of Form OIR-1162 (3/95) are acceptable, provided that the copies are clearly legible and contain no alterations in text and type size.~~

(3) The disclosure shall be signed by the insured.

(4) Copies of the signed disclosure shall be given to the agent, insured, and the premium finance company.

*Rulemaking ~~Specific~~ Authority 627.8405 FS. Law Implemented 624.424, 626.9541(1)(a), 627.734, 627.8405 FS. History–New 3-1-95, Amended 8-16-95, Formerly 4-196.021 Amended_____.*

**69O-196.025 Statement of Account; Receipts.**

(1) The Office has adopted a standard form which is acceptable for the use of premium finance companies in meeting the requirements of this part. Upon request of the premium finance company, the Office will provide form OIR-970, which is incorporated by reference in Rule 69O-196.015, F.A.C., from which the company may make as many copies as necessary. Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

(2) In the alternative, a premium finance company may submit its own form to the Office for approval, together with the appropriate form filing fee, which form must contain the same information at a minimum, in any logical configuration.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 627.845, 626.9541(1)(a) FS. History–New 7-27-95, Formerly 4-196.025 Amended_____.*

**69O-196.035 Required Books and Records.**

At a minimum for permanent books and records, each licensed premium finance company shall maintain:

(1) A complete set of accounting records including but not limited to:

(a) A general ledger;

(b) Cash receipts and disbursements journals;

(c) Accounts receivable registers; and

(d) Accounts payable registers; together with supporting documentation evidencing each entry.

(2) A detailed register of premium finance contracts in force. The register shall include:

(a) Date of issue;

(b) Issuing agent and address;

(c) Name and address of the insured;

(d) Policy period;

(e) Policy number;

(f) Type of policy;

(g) Total premium;

(h) Down payment;

(i) Documentary stamp tax;

(j) Amount financed;

(k) Finance charges;

(l) Number of payments; and

(m) Amount of each payment.

(3) A detailed payment history of each premium finance contract, supported by, at a minimum, copies of any and all correspondence, notices, contracts, and agreements between the premium finance company and any other person, related to the contract.

(4) A record of receipts and disbursements relative to each contract, including supporting documentation therefor.

(5) Copies of all forms and rates utilized by the premium finance company bearing the approval stamp of the Office.

(6) Evidence of compliance with the financial requirements of Section 627.828, F.S.

(7) A detailed register of all contracts assigned including at a minimum the following information:

(a) Date of contract;

(b) Date contract funded;

(c) Date assigned;

(d) To whom assigned;

(e) Dollar amount of contract;

(f) Amount received;

(g) Name of issuing agent.

(8) A detailed register of all contracts accepted for assignment from others, including at a minimum the following information:

(a) Date of contract;

(b) Date assigned;

(c) From whom assignment accepted;

(d) Dollar amount of contract;

(e) Amount paid;

(f) Name of issuing agent.

(9) Copies of all contracts with independent contractors or third parties performing services directly or indirectly related to the premium finance business. Each such contract shall be submitted to the Office and shall contain at a minimum the following provisions: All filings shall be submitted electronically to http://www.floir.com/iportal.

(a) Specific details as to the services to be provided to or on behalf of the licensee;

(b) Specific details concerning the charges to be paid by the licensee for these services, including the method of calculation;

(c) A clause whereby the Office reserves the right to require the licensee to alter or void any contract provision or part thereof which violates the Florida Insurance Code.

(d)1. A clause providing that all books and records of the person providing services pertaining to the licensee shall be made available to the Office for examination, which shall include at a minimum those books and records specified in subsections (1)-(8) of this rule as they apply to the services rendered to the licensee.

2. All persons providing marketing services shall maintain and make available to the Office a register of the names and addresses of all agents solicited on behalf of the licensee, together with the number of contracts provided to the licensee by each agent and a record of any payments to or from these agents related thereto.

3. Contract terms or provisions notwithstanding, the licensee remains responsible for the acts of any person it hires or otherwise

engages to act on its behalf.

(10) Records maintained in accordance with this rule shall be kept as originals, photocopies, or electronically stored reproductions.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 627.828, 627.834, 627.836, 627.838, 627.840, 627.8405, 627.841, 627.844, 627.845, 627.848, 627.849 FS. History–New 7-27-95, Formerly 4-196.035 Amended _____.*

**69O-198.010 License Continuance.**

(1)(a)1. All service warranty association licenses shall continue in force as long as the service warranty association is in compliance with the provisions of Chapter 634, Part III, Florida Statutes.

2. The qualified license holder shall file for continuance of its license on the form prescribed by the Office.

3. 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) Form OIR-A3-110 and a fee of $200.00 should be received by the Office annually in conjunction with the March 1 filing of the annual statement.

(c) A manufacturer or affiliate should use Form OIR-A3-955, which should be received by the Office annually in conjunction with the March 1 filing of the annual statement, together with a fee of $500.00.

(2) Any licensee who fails to renew said license shall immediately cease and desist from engaging in the Service Warranty business in the State of Florida. The association shall honor those warranty contracts in force until date of expiration or date of cancellation and a refund made to the consumer.

(3) Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 634.402 FS. Law Implemented 624.424, 634.408 FS. History–New 12-26-88, Formerly 4-67.010, Amended 3-28-93, Formerly 4-198.010 Amended_____.*

**69O-198.012 Annual Statement and Quarterly Reports.**

(1) An Annual Statement is required to be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on or before March 1 of each year on Form OIR-A3-456 (05/90) as incorporated by reference in subsection 69O-198.015(1), F.A.C. If the statement is not complete to include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.

(2) Quarterly Reports are required to be filed with the Office of Insurance Regulation~~, Bureau of Allied Lines,~~ on the form prescribed by the Office. If Quarterly Reports are not complete to include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected. Failure to file the Quarterly Reports in a timely manner may result in administrative action to suspend or revoke the license.

(3) The Quarterly Reports are due as follows:

| PERIOD | DUE |
|---|---|
| First Quarter (March 31) | May 15 |
| Second Quarter (June 30) | August 15 |
| Third Quarter (September 30) | November 15 |

(4) Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 634.402 FS. Law Implemented 624.424, 634.415 FS. History–New 12-26-88, Amended 4-26-90, Formerly 4-67.012, 4-198.012 Amended_____.*

**69O-198.015 Forms Incorporated by Reference.**

(1) The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 634, Part III, Florida Statutes:

| Form Number | Title |
|---|---|
| (a) OIR-987 (02/92) | Application Cover letter (Manu) |
| (b) OIR-989 (02/92) | App. Instructions (Manu) |
| (c) OIR-986 (02/92) | App. Checklist (Manu) |
| (d) OIR-988 (02/92) | Invoice (Manu) |
| (e) OIR-991 (01/92) | Application (Manu) |
| (f) OIR-996 (01/92) | Application Cover letter (SWA) |
| (g) OIR-997 (01/92) | App. Instructions (SWA) |
| (h) OIR-998 (01/92) | App. Checklist (SWA) |
| (i) OIR-999 (01/92) | Invoice (SWA) |
| (j) OIR-903 (09/91) | Fingerprint Fee Invoice |
| (k) OIR-167 (01/92) | Application (SWA) |
| (l) OIR-144 (11/90) | Consent to Service of Process |
| (m) OIR-514 (11/90) | Resolution Form |
| (n) OIR-969 (08/92) | Contractual Liability Policy |
| (o) OIR-981 (02/92) | Instructions for Securities Deposit |
| (p) OIR-844 (10/91) | Management Information |
| (q) OIR-973 (10/91) | Stockholder Listing |
| (r) OIR-422 (11/90) | Biographical Stmt. |
| (s) OIR-449 (01/91) | Abbreviated Bio. |
| (t) OIR-450 (08/91) | Release of Info. |
| (u) OIR-455 (01/89) | Service Warranty Bond |
| (v) OIR-934 (10/91) | Equifax Instructions |
| (w) OIR-938 (04/91) | Fingerprint Instructions |
| (x) OIR-456 (05/90) | Annual Statement |

| | |
|---|---|
| (y) OIR-457 (05/90) | Quarterly Report |
| (z) OIR-110 (02/92) | Continuance Form (SWA) |
| (aa) OIR-955 (02/92) | Continuance Form (Manu) |
| (bb) OIR-458 (02/92) | Annual Statement for Publicly Held Corporation |

(2) Forms are available at http://www.floir.com/iportal. ~~These forms shall become effective on the effective date of this rule. Copies of the forms may be obtained from the Office of Insurance Regulation, Bureau of Specialty Insurers, 200 East Gaines Street, Tallahassee, FL 32399-0300.~~

*Rulemaking ~~Specific~~ Authority 634.402 FS. Law Implemented 624.424, 634.405, 634.407, 634.408, 634.4085, 634.415 FS. History–New 12-26-88, Amended 5-28-90, Formerly 4-67.015, Amended 3-28-93, Formerly 4-198.015 Amended_____.*

**69O-199.008 General Eligibility Requirements.**

(1) Biographical statements (Form OIR-422 as adopted in Rule 69O-199.015, F.A.C., on the following persons shall be included in the application for a Certificate of Authority (COA):

(a) Persons who own or control in excess of five percent of the outstanding stock of the home warranty association;

(b) Members of the board of directors of the home warranty association;

(c) All officers who are identified in Section 634.306, Florida Statutes, and any other individuals who have policy decision making authority;

(d) All officers and directors of any parent corporation or corporations of the home warranty association, if parent exists; and,

(e) All officers and directors of any external management company contracted with the home warranty association, if management company exists, pursuant to paragraph (c) above.

(2) This requirement also applies to individuals who, subsequent to the date of application for a COA, become associated with a home warranty association and meet any of the qualifications listed in paragraphs (a) through (e) above.

(3) Home warranty associations are required to notify the Office in writing within 15 days of any new officers, directors, or stockholders owning 5% or more of the outstanding voting securities of the home warranty association.

(4) Home warranty associations are required to notify the Office in writing within 15 days of any change in the corporate name, business name, trademark, or emblem of the association.

(5) All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 634.302 FS. Law Implemented 624.424, 634.304, 634.306, 634.3073, 634.313 FS. History–New 7-16-92, Amended 4-3-94, Formerly 4-199.008 Amended_____.*

**69O-199.010 License Renewal.**

(1)(a) All home warranty association licenses shall expire on June 1.

(b) The qualified license holder shall file for renewal of its license on the form prescribed by the Office.

(c) The renewal form and a fee of $200.00 shall be received by the Office annually at least 30 days prior to June 1 of each year. All filings shall be submitted electronically to http://www.floir.com/iportal.

(d) Failure to submit the application for renewal by June 1 shall result in expiration of the license, and will require the filing of a new application for licensure.

(2)(a) Any licensee who fails to renew said license shall immediately cease and desist from engaging in the Home Warranty business in the State of Florida.

(b) The association shall honor those warranty contracts in force until date of expiration or date of cancellation, with a refund made to the consumer, provided by written contract.

*Rulemaking ~~Specific~~ Authority 634.302 FS. Law Implemented 624.424, 634.307 FS. History–New 7-16-92, Amended 4-3-94, Formerly 4-199.010 Amended_____.*

**69O-199.012 Annual Statement ~~and Quarterly Reports.~~**

(1)(a) An annual statement shall be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on or before March 1 of each year on the form prescribed by the Office.

(b) If the statement does not include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.

(2) A late filing fee will be assessed in accordance with Rule Chapter 69O-207, F.A.C., for each company that has not filed a complete annual statement in accordance with this rule.

~~(3) (a) Quarterly reports shall be filed with the Office of Insurance Regulation, Bureau of Specialty Insurers, on the form prescribed by the Department.~~

~~(b) If the quarterly report does not include substantially all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.~~

~~(c) Failure to timely file the quarterly reports may result in administrative action to suspend or revoke the license.~~

~~(4) The Quarterly Reports are due as follows:~~

| ~~Period~~ | ~~Due~~ |
|---|---|
| ~~First Quarter (March 31)~~ | ~~May 15~~ |
| ~~Second Quarter (June 30)~~ | ~~August 15~~ |
| ~~Third Quarter (September 30)~~ | ~~November 15~~ |

(3) ~~(5)~~(a) Any request for an extension of filing the annual report shall be in writing and the reason(s) for the extension explained in detail.

(b) All requests must be filed with the Office fifteen (15) days prior to the deadline date for filing the annual report.

(c) Any extension request received less than fifteen (15) days prior to due date will be denied except for unavoidable circumstances, which include for example:

1. Death of key personnel, or

2. Destruction of records by fire, hurricane, or other natural disasters.

(4) All filings shall be submitted electronically at http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 634.302, 634.308(1)(a) FS. Law Implemented 624.307(1), 624.424, 634.313 FS. History–New 7-16-92, Amended 4-3-94, Formerly 4-199.012 Amended_____.*

**69O-199.015 Forms Incorporated by Reference.**

(1) The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 634, Part II, Florida Statutes:

| Title | Form Number |
|---|---|
| (a) Application for Home Warranty Association License | OIR-490 (02/90) |
| (b) Annual Report | OIR-491 (03/91) |
| (c) Quarterly Report | OIR-492 (03/91) |
| (d) Statement of Acquisition | OIR-448 (05/89) |
| (e) Consent and Agreement in re Service of Process | OIR-144 (11/90) |
| (f) Authority to Release Information | OIR-450 (08/91) |
| (g) Biographical Statement and Affidavit | OIR-422 (11/90) |
| (h) Abbreviated Biographical Statement | OIR-449 (01/91) |
| (i) Home Warranty Bond | OIR-455 (01/89) |
| (j) Certification of Filing Annual Tax on Premiums and Assessment | OIR-440 (12/89) |
| (k) Resolution Form | OIR-514 (11/90) |
| (l) Renewal Notice | OIR-1073 (04/92) |

(2) Forms are available at http://www.floir.com/iportal. ~~These forms are effective on the dates referenced above. Copies of the forms may be obtained from the Office of Insurance Regulation, Bureau of Specialty Insurers, Larson Building, Tallahassee, FL 32399-0300.~~

*Rulemaking ~~Specific~~ Authority 634.302 FS. Law Implemented 624.424, 634.306, 634.3073, 634.3077, 634.313, 634.315 FS. History–New 7-15-90, Formerly 4-118.015, Amended 7-16-92, Formerly 4-199.015 Amended_____.*

**69O-200.015 Forms Incorporated by Reference.**

(1) The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 634, Part I, F.S.:

| Title | Form Number |
|---|---|
| (a) Application Cover Letter | OIR-CI-982 (02/92) |
| (b) Application Instructions | OIR-CI-994 (02/92) |
| (c) Application Checklist | OIR-CI-993 (02/92) |
| (d) Fingerprint Fee Invoice | OIR-CI-903 (09/91) |
| (e) Application for License as a Motor Vehicle Service Agreement Company | OIR-CI-469 (02/92) |
| (f) Consent to Service of Process | OIR-CI-144 (11/90) |
| (g) Resolution Form | OIR-CI-514 (11/90) |
| (h) Statement of Acquisition | OIR-CI-448 (05/89) |
| (i) Sample Contractual Liability Policy | OIR-CI-969 (08/92) |
| (j) Instructions for Deposit | OIR-CI-992 (05/94) |
| (k) List of Salesman | OIR-CI-995 (02/92) |
| (l) Management Information | OIR-CI-844 (10/91) |
| (m) Stockholder Listing | OIR-CI-973 (10/91) |
| (n) Biographical Statement | OIR-CI-1423 (09/08) http://www.flrules.org/Gateway/reference.asp?No=Ref-01063 |
| (o) Release of Information | OIR-CI-450 (08/92) |
| (p) Equifax Instructions | OIR-CI-934 (10/91) |
| (q) Fingerprint Instructions | OIR-CI-938 (04/91) |
| (r) Annual Statement | OIR-A3-467 (01/92) |
| (s) Quarterly Report | OIR-A3-466 (02/87) |
| (t) Application for License Motor Vehicle Service Agreement Company Manufacturer | OIR-A3-1983 (10/19/2011) http://www.flrules.org/Gateway/reference.asp?No=Ref- |

| | |
|---|---|
| | 01064 |
| (u) Annual Report for Motor Vehicle Manufacturers | OIR-A3-1984 (10/19/2011) http://www.flrules.org/Gateway/reference.asp?No=Ref-01060 |
| (v) Application for Exemption from Field Examination | http://www.flrules.org/Gateway/reference.asp?No=Ref-01062 |
| (w) Application for License Continuance Motor Vehicle Service Agreement Company | OIR-A3-1985 (01/10) http://www.flrules.org/Gateway/reference.asp?No=Ref-01065 |
| | OIR-A3-2019 (01/10) http://www.flrules.org/Gateway/reference.asp?No=Ref-01066 |

(2) Forms are available at http://www.floir.com/iportal. ~~These forms are effective on the dates referenced above. Copies of the forms may be obtained from the Office of Insurance Regulation at www.floir.com.~~

*Rulemaking Authority 634.021 FS. Law Implemented 624.424, 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, Amended* _____

**69O-201.010 License Continuance.**

(1)(a) All legal expense insurance corporation licenses shall continue in force as long as the legal expense insurance corporation is in compliance with the provisions of Chapter 642, Florida Statutes.

(b) The qualified license holder shall file for continuance of its license on form OIR-A3-1077 adopted in Rule 69O-201.015, F.A.C. Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

(c) The renewal notice and application form and a fee of $200.00 must be received by the Office prior to June 1 of each year.

(d) Failure to submit by June 1 shall result in expiration of the license, and will require filing a new application for licensure.

(2)(a) Any licensee who fails to continue said license shall immediately cease and desist from engaging in the Legal Expense Insurance business in the State of Florida.

(b) The corporation shall honor those contracts in force until date of expiration or date of cancellation and a refund made to the consumer.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 642.032 FS. History–New 6-23-92, Formerly 4-201.010 Amended_____.*

**69O-201.012 Annual Statement and Quarterly Reports.**

(1)(a) An annual statement and a $60 filing fee shall be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on or before March 1 of each year on form OIR-A3-479 adopted in Rule 69O-201.015, F.A.C.

(b) If the statement does not include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.

(2) A late filing fee will be assessed in accordance with Rule 69O-207.001, F.A.C., for each day after March 1 that a company has not filed a complete annual statement.

(3)(a) Quarterly reports shall be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on form OIR-481 as adopted in Rule 69O-201.015, F.A.C.

(b) If the quarterly report does not include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.

(c) Failure to file the quarterly reports in a timely manner may result in administrative action to suspend or revoke the license.

(4) The quarterly reports are due as follows:

| Period | Due |
|---|---|
| First Quarter (March 31) | May 15 |
| Second Quarter (June 30) | August 15 |
| Third Quarter (September 30) | November 15 |

(5)(a) Any request for an extension of filing the annual report shall be in writing, and the reason(s) for the extension explained in detail.

(b) All requests must be filed with the Office fifteen (15) days prior to the deadline date for filing the annual report.

(c) Any extension request received less than fifteen (15) days prior to due date will be denied except for unavoidable circumstances, which include but are not limited to:

1. Death of key personnel, or

2. Destruction of records by fire, hurricane, or other natural disasters.

(6) All filings shall be submitted electronically to http://www.floir.com/iportal.

*Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 642.032 FS. History–New 6-23-92, Formerly 4-201.012 Amended_____.*

**69O-207.001 Late Filed Reports - Fine Schedule.**

(1) The following schedule of fines is hereby adopted by the Commission as a guideline in assessing fines against the referenced entities for the late filing of annual reports or statements as required by law:

| Entity | A | B | Maximum Fine |
|---|---|---|---|
| (a) Continuing Care (651.026(1) and 651.015(2)(c)) | $25 per day and 50% of renewal fee | $50 per day and 50% of renewal fee | None |
| (b) Preneed Funeral (639.10) | $12.50 per day each for Part I and Part II of Report | $25.00 per day for Part I and Part II of Report | None |
| (c) Health Maintenance Organizations (641.26(3)) | $100 per day | $200 per day | $100,000 |
| (d) Prepaid Health Clinics (641.41(2)) | $25 per day | $50 per day | None |
| (e) Prepaid Dental (637.423) | $12.50 per day | $25 per day | $1,000 |
| (f) Ambulance Service (638.122(2)) | $12.50 per day | $25 per day | $500 |
| (g) Pharmaceutical Contracts (637.278(2)) | $12.50 per day | $25 per day | $500 |
| (h) Prepaid | $12.50 per day | $25 per day | $500 |

| | | | |
|---|---|---|---|
| Optometric (637.118(2)) | | | |
| (i) Multiple Employer Welfare Arrangements (624.4211(2)) | $100.00 per day | $200 per day | $2,500 |
| (j) Automobile Warranty (634.131(3)) | $100 per day | $100 per day | None |
| (k) Home Warranty (634.313(3)) | $25 per day | $50 per day | None |
| (l) Premium Finance (626.681) | $12.50 per day | $25 per day | $500 |
| (m) Prepaid Legal (642.0338(2)) | $12.50 per day | $25 per day | $1,000 |
| (n) Service Warranty (634.415(3)) | $50 per day | $100 per day | None |
| (o) Insurance Administrators (626.894(2)) | $12.50 per day | $25 per day | $1,000 |

"A" is applicable if the entity filed late last year and filed late this year, but within 5 days after notice or if timely filed last year and late by more than five days after notice in current year. "B" is applicable if the entity filed late last year and filed late in current year more than 5 days after notice.

(2) The fines provided in subsection (1) above may be increased or decreased based on the following mitigating and aggravating factors:

(a) Mitigating:

1. The entity has given advance notice to the Office that it will be filing late.

2. Justifiable unforeseen cause not within control of entity.

3. The entity has timely submitted major portions of the report.

4. Other mitigating factors as the Office may determine on the facts of the particular situation.

(b) Aggravating:

1. The entity has not given prior notice to the Office that it will be filing late.

2. Adverse financial condition indicated when report is filed.

3. Past violations by the entity.

4. Willfully or intentionally failing to file the report.

(3) The fines referenced in subsection (1) above are in addition to any other penalties that may be allowed by law, including the summary suspension of authority to transact business until the report is filed.

(4) For purposes of this rule an annual report or statement, required by law, is deemed received by the Office on the date it is submitted electronically at http://www.floir.com/iportal.~~postmarked by the official U. S. Postal Service Cancellation. Metered mail is not acceptable to meet this requirement. If metered mail is utilized or there is no official U. S. Postal Service Cancellation, the date stamped "received" by the Office will be deemed the date received.~~

*Rulemaking ~~Specific~~ Authority 624.308(1), 634.021, 634.302, 634.402, ~~637.165~~, 637.325, ~~638.031~~, 639.08, 641.36, 641.403, 651.015 FS. Law Implemented 624.307(1), 624.4211(2), 624.424, 626.681, 626.894(2), ~~634.131(3),~~ 634.313(3), 634.415(3), 637.118(2), 637.278(2), 637.423, ~~638.122(2),~~ ~~639.10~~, 641.26(3), 641.41(2), 642.0338(2), ~~652.026(1)~~ FS. History–New 1-28-91, Formerly 4-120.001, 4-207.001 Amended_____.*

**69O-137.008 Filing of Statistical and Quarterly Reports for Individually Rated Risks and Excess Rates.**

(1) Purpose and Scope. The purpose of this rule is to provide procedures for filing statistical reports for individually rated risks pursuant to Section 627.062(3)(a), F.S., and for excess rates pursuant to Section 627.171, F.S., since they are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules which have been filed with the Office. Every insurer in this state which is authorized to transact any of the lines of insurance subject to Part II of Chapter 627, F.S. Reports for individually rated risks and excess rates shall be received by the Office on a quarterly basis for each company. The information shall be reported within 45 days of the close of each quarter on Form OIR-B1-588, "Office of Insurance Regulation/Property & Casualty – Quarterly Report/Individually Rated Risks and Excess Rates," rev. 8/94, which is hereby adopted and incorporated by reference. A quarterly report need not be filed if no individually rated risks or risks subject to excess rates have been written during the quarter for which the report would otherwise be due. However, if an insurer does not file Form OIR-B1-588 because of not having written such business for four consecutive quarters, then for the quarter after the fourth consecutive quarter for which no business was written, the insurer shall file Form OIR-B1-588 and check the box thereon indicating that the insurer has not been subject to filing for the past four consecutive quarters. The form may be obtained from http://www.floir.com/iportal ~~the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0330.~~ A separate report must be completed for each quarter. The reports are due 45 days after the close of each quarter.

(3) Submitting the Report. Forms may be submitted by mailing a completed electronic version via email to OIRB1588@floir.com or by mailing a copy to Property and Casualty Product Review Unit, Office of Insurance Regulation, 200 E. Gaines St., Tallahassee, FL 32399-0330.

~~(a) The insurer shall affix the bar code labels to the upper right-hand corner of Form OIR-B1-588, and shall mail the report to the following address: Office of Insurance Regulation, Post Office Box 5320, Tallahassee, Florida 32314-5320.~~

~~(b) Questions concerning bar code labels shall be directed to the Office of Insurance Research and Data Analysis at (850)922-3149, ext. 2676. Orders for additional bar code labels shall be submitted in writing, shall state the company's most current FEIN number, and shall be accompanied by a payment in the amount of $30 per company, to the Office of Insurance Research and Data Analysis at the address in paragraph (3)(a), above.~~

~~(c) Original forms with bar codes may be copied for use with future filings. The insurer is encouraged to keep the original bar code form for future copying and to mail only the copies.~~

*Rulemaking Authority 624.308(1), 627.331(1) FS. Law Implemented 624.307(1), 624.418, 624.4211, 624.424(6), 627.062, 627.171, 627.331 FS. History–New 6-9-93, Amended 9-19-94, Formerly 4-137.008 Amended_____.*

**69O-167.011 Homeowner's Policies: Offer of Replacement Cost Coverage and Law and Ordinance Coverage.**

(1) This rule applies to all covered losses arising from claims under homeowners policies as that term is generally used but does not apply to a tenant's form, commonly known as an HO-4 nor to a condominium unit owner's form, commonly known as an HO-6.

(2) Pursuant to Section 627.7011, F.S., insurers are required to obtain a written statement from the holder of a homeowner's policy regarding that policyholder's selection or rejection of replacement cost coverage and law and ordinance coverage, as those coverages are described in Section 627.7011, F.S. Insurers are also required to provide each homeowner's policyholder with notice of the availability of these coverages at least once every three years. However, an insurer is not required to make the offers required by this rule with respect to the issuance or renewal of a homeowners policy which contains the provisions specified in Section 627.7011(1)(b), F.S.

(3) Insurers shall obtain ~~the required written statement in one of two ways. The insurer may use Form OIR-1148, "Rejection or Selection of Important Additional Coverages," rev. 4/94, which is hereby adopted and incorporated by reference. Insurers using Form OIR-1148 must use that same form to provide the required notice of availability every three years. Copies of the form may be obtained from the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0330. The form may be reproduced at will. Alternatively, the insurer may use its own form if the form is approved by the Office. A request for approval shall be submitted to the Bureau of Property and Casualty Forms and Rates and the Office will approve the form if it contains substantially the same explanation and check-off opportunities as Form OIR-1148. If an insurer receives~~ approval to use its own form,and ~~the insurer~~ must use an approved ~~that same~~ form for the required notification every three years. Such ~~Whichever~~ form ~~is~~ used by the insurer shall be retained by the insurer in the policyholder's file.

(4) If the insurer already includes replacement coverage and law and ordinance coverage as an integral part of its homeowners policy form, it is not necessary to obtain an explicit selection or rejection from the policyholder. However, the insurer shall include an explanation of the coverages in order to fully advise the applicant or policyholder of the nature of the coverages, as required by Section 627.7011(2), F.S.

*Rulemaking Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.7011 FS. History–New 11-2-94, Formerly 4-167.011 Amended_____.*

**69O-170.007 Annual Rate Filings.**

(1)(a) This rule applies to each insurer or rating organization subject to Section 627.0645, F.S.

(b)1. Commercial Multiple Line insurance, for purposes of this rule, is defined as insurance that includes a combination of one or more property lines of insurance, e.g., fire and allied lines, and one or more casualty lines of insurance, e.g., general liability, burglary and theft.

2. Commercial Multiple Line insurance shall be interpreted as being the same as Commercial Multiple Peril insurance.

3. Commercial Multiple Line insurance or Commercial Multiple Peril insurance which is written on an indivisible premium basis is subject to this rule.

4. Divisible premium Commercial Multiple Peril policies shall not be subject to this rule.

(c) A base rate filing considers the overall rate level and individual components of a line or subline being reviewed, although all are not necessarily revised in a base rate filing. A base rate filing may include, for example, a package modification factor.

(d) For purposes of identifying filings submitted to the Office, a line of business shall be identified by one of the following, although additional identification may be used as needed:

~~1. Commercial Automobile;~~

12. Commercial Multiple Peril Policy (with indivisible premium);

23. Dwelling Fire and Liability;

34. Homeowners;

45. Mobile Homeowners;

56. Motor Home and Motorcycle;

67. Personal Inland Marine;

78. Personal Liability; and

89. Private Passenger Automobile.

(2) Each insurer or each rating organization filing rates for one or more insurers shall make annual base rate filings with the Office for each line or subline of insurance no later than 12 months after its previous certification or base rate filing effective date for new business.

(3)(a) Filings shall be submitted in accordance with the requirements of this rule.

1. Filings submitted in accordance with paragraph (4)(a) below, shall demonstrate that the rates filed are not excessive, inadequate, or unfairly discriminatory, and

2. Filings submitted in accordance with paragraph (4)(b), below, shall demonstrate that the rates are actuarially sound and not inadequate.

(b)1. The filings required by this rule shall be on an individual insurer basis unless the rates for insurers within a group are derived from the pooled experience of those insurers.

2. If the rates for more than one insurer within a group are derived from pooled experience, then the filing may be made on a multiple insurer basis but the cover letter for the filing shall explicitly state what the rates are and what insurers are included in the group. Insurers may submit a filing on behalf of any combination of insurers within the insurers' group, provided the effective dates are identical for every insurer and program identified in the filing.

(c)1. The insurer shall submit all filings to the Office at http://www.floir.com/iportal. ~~https://iportal.fldfs.com, the industry portal to the Office's I-File System, as adopted in Rule 69O-170.0155, F.A.C.~~

2. A filing shall be considered received by the Office on business days between the hours of 8:00 a.m. and 5:00 p.m. eastern time. Filings received after 5:00 p.m. shall be considered to be received the next business day.

(4) The filing required by this rule shall be satisfied by either paragraph (a) or (b) below:

(a) A rate filing prepared by or under the direct supervision of an actuary. The filing shall be signed by the actuary and shall contain documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory, and be submitted pursuant to Rule 69O-170.013, F.A.C.

(b)1. If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate.

2. Form OIR-B1-582, "Universal Standardized Data Letter," as adopted in Rule 69O-170.0155, F.A.C.

3. Form OIR-B1-586, "Florida Property and Casualty – Annual Rate Filings Certification," as adopted in Rule 69O-170.0155, F.A.C.

4. The data shall be on a direct basis.

(c) If an insurer does not employ or otherwise retain the services of an actuary, as defined by Section 627.0645(8), F.S., the filing under paragraph (a) or (b) above shall:

1. Be prepared by a person meeting the requirements of Section 627.0645(5), F.S., herein referred to as a qualified ratemaker.

2. Be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.

3. Include detailed information on the preparer's experience to demonstrate compliance with Section 627.0645(5), F.S.

4. Include a certification of an officer of the insurer that the insurer does not employ or otherwise retain the services of an actuary.

5. If the submission does not contain the material required by this paragraph (c), it will result in the Office's issuance of a Notice of Intent to disapprove.

(d)1. For purposes of this rule, a prospective loss cost filing, using the most recently approved loss costs, submitted to the Office by a duly authorized rating organization, may be considered as part of a base rate filing.

2. The factors for converting loss costs to rates shall be filed by the submitting insurer and approved by the Office.

3. All deviations from a rating or advisory organization's loss costs are to be certified or adequately supported.

4. An insurer may choose:

a. To file and distribute final rate pages;

b. To file or reference loss cost pages filed and distributed by a rating organization; or

c. To file loss cost pages distributed by an advisory organization plus the insurer's factors used to convert the prospective loss costs to rates.

5. An insurer shall use Form OIR-B1-583, "Florida Expense Supplement Calculation of Insurer Loss Cost Multiplier," as adopted in Rule 69O-170.0155, F.A.C., in filing the factors to convert a rating or advisory organization's prospective loss costs to rates and shall comply with Rule 69O-170.013, F.A.C.

(e)1. A request for exemption pursuant to Section 627.0645(2)(b), F.S., shall include Form OIR-B1-584, "Florida Property and Casualty – Annual Rate Filing-Exemption," as adopted in Rule 69O-170.0155, F.A.C. and shall be submitted through http://www.floir.com/iportal ~~https://iportal.fldfs.com~~.

2. The exemption shall remain in effect for as long as there is not an increase in premium volume.

(5) A request for extension meeting the conditions of Section 627.0645(6), F.S., will be approved automatically upon receipt.

*Rulemaking ~~Specific~~ Authority 624.308, 624.424(1)(c) FS. Law Implemented 624.307, 624.418(2), 624.4211, 624.424(1)(c), 627.021, 627.062, 627.0645, 627.0651, 627.221, 627.301 FS. History–New 12-25-90, Formerly 4-72.007, Amended 1-27-92, 3-9-93, 9-7-93, 12-17-00, Formerly 4-170.009, Amended 9-5-07 Amended_____.*

**69O-175.021 Insurer Experience Reporting - Excessive Profits, Automobile Insurance.**

(1) Any insurer authorized to transact private passenger automobile insurance in the state shall report the information required by Sections 627.931(1) and 627.066, F.S., or required by rule, by completing and submitting to the Office of Insurance Regulation form OIR-307 "Private Passenger Automobile Excessive Profits Reporting Form" in accordance with the instructions provided therein.

(2) For purposes of this rule, "insurer group" shall mean one or more insurers operating under common management.

(3) Reports are due on or before July 1st of each year.

(4) Form OIR-B1-307, shall be submitted electronically through the Data Collection and Analysis Module (DCAM) at http://www.floir.com/iportal.~~as amended, shall take effect on the amended date of this rule.~~

*Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.066, 627.915(1) FS. History–New 1-16-83, Amended 6-14-84, Formerly 4-59.06, 4-59.006, Amended 1-27-92, Formerly 4-175.021 Amended_____.*

690-144

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.610 Reinsurance.—
(1) The purpose of this section is to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. It is the intent of the Legislature to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislature requires that upon the insolvency of a non-United States insurer or reinsurer which provides security to fund its United States obligations in accordance with this section, such security shall be maintained in the United States and claims shall be filed with and valued by the state insurance regulator with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in this section are fundamental to the business of insurance in accordance with 15 U.S.C. ss. 1011-1012.
(2) Credit for reinsurance must be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (3)(a), paragraph (3)(b), or paragraph (3)(c). Credit must be allowed under paragraph (3)(a) or paragraph (3)(b) only for cessions of those kinds or lines of business that the assuming insurer is licensed, authorized, or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed or authorized to transact insurance or reinsurance.
(3)(a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is authorized to transact insurance or reinsurance in this state.
(b)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. An accredited reinsurer is one that:
a. Files with the office evidence of its submission to this state's jurisdiction;
b. Submits to this state's authority to examine its books and records;
c. Is licensed or authorized to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through, licensed, or authorized to transact insurance or reinsurance in at least one state;
d. Files annually with the office a copy of its annual statement filed with the insurance department of its state of domicile any quarterly statements if required by its state of

domicile or such quarterly statements if specifically requested by the office, and a copy of its most recent audited financial statement; and
(I) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the office within 90 days after its submission; or
(II) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has been approved by the office.
2. The office may deny or revoke an assuming insurer's accreditation if the assuming insurer does not submit the required documentation pursuant to subparagraph 1., if the assuming insurer fails to meet all of the standards required of an accredited reinsurer, or if the assuming insurer's accreditation would be hazardous to the policyholders of this state. In determining whether to deny or revoke accreditation, the office may consider the qualifications of the assuming insurer with respect to all the following subjects:
a. Its financial stability;
b. The lawfulness and quality of its investments;
c. The competency, character, and integrity of its management;
d. The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer; and
e. Whether claims under its contracts are promptly and fairly adjusted and are promptly and fairly paid in accordance with the law and the terms of the contracts.
3. Credit must not be allowed a ceding insurer if the assuming insurer's accreditation has been revoked by the office after notice and the opportunity for a hearing.
4. The actual costs and expenses incurred by the office to review a reinsurer's request for accreditation and subsequent reviews must be charged to and collected from the requesting reinsurer. If the reinsurer fails to pay the actual costs and expenses promptly when due, the office may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.
(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (5)(b), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.
2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:
(I) The insurance regulator of the state in which the trust is domiciled; or
(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.
b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.
c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.
3. The following requirements apply to the following categories of assuming insurer:

a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.

b.(I) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust consists of a trusteed 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;

(B) 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 section, the trust consists of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and

(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

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

(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(d) Credit must be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), or paragraph (c), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required to be purchased by a particular entity by applicable law or regulation of that jurisdiction.

(e) If the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), paragraph (c), or paragraph (d), the commissioner may allow credit, but only if the assuming insurer holds surplus in excess of $250 million and has a secure financial strength rating from at least two statistical rating organizations deemed acceptable by the commissioner as having experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Service, Fitch Ratings, A.M. Best Company, and Demotech. In determining whether credit should be allowed, the commissioner shall consider the following:

1. The domiciliary regulatory jurisdiction of the assuming insurer.
2. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and the financial surveillance of the reinsurer.
3. The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction.
4. The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles.

5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the office in particular.
6. The history of performance by reinsurers in the domiciliary jurisdiction.
7. Any documented evidence of substantial problems with the enforcement of valid United States judgments in the domiciliary jurisdiction.
8. Any other matters deemed relevant by the commissioner. The commissioner shall give appropriate consideration to insurer group ratings that may have been issued. The commissioner may, in lieu of granting full credit under this subsection, reduce the amount required to be held in trust under paragraph (c).
(f) If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state pursuant to paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) must not be allowed unless the assuming insurer agrees in the reinsurance agreements:
1.a. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and
b. To designate the Chief Financial Officer, pursuant to s. 48.151, or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.
2. This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.
(g) If the assuming insurer does not meet the requirements of paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) is not allowed unless the assuming insurer agrees in the trust agreements, in substance, to the following conditions:
1. 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 paragraph (c), 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 United States court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight all of the assets of the trust fund.
2. The assets must be distributed by and claims must be filed with and valued by the insurance regulator with regulatory oversight in accordance with the laws of the state in which the trust is domiciled which are applicable to the liquidation of domestic insurance companies.
3. If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof must be returned by the insurance regulator with regulatory oversight to the trustee for distribution in accordance with the trust agreement.
4. The grantor shall waive any right otherwise available to it under United States law which is inconsistent with this provision.
(4) An asset allowed or a deduction from liability taken for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of subsections (2) and (3) is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The deduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is

held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (5)(b). This security may be in the form of:
(a) Cash in United States dollars;
(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets pursuant to part II of chapter 625;
(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or
(d) Any other form of security acceptable to the office.
(5)(a) For purposes of paragraph (4)(c) regarding letters of credit, a "qualified United States financial institution" means an institution that:
1. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state thereof;
2. Is regulated, supervised, and examined by United States or state authorities having regulatory authority over banks and trust companies; and
3. Has been determined by either the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the office.
(b) For purposes of those provisions of this law which specify institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that is a member of the Federal Reserve System or that has been determined by the office to meet the following criteria:
1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and
2. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.
(6) For the purposes of this section only, the term "ceding insurer" includes any health maintenance organization operating under a certificate of authority issued under part I of chapter 641.
(7) After notice and an opportunity for a hearing, the office may disallow any credit that it finds would be contrary to the proper interests of the policyholders or stockholders of a ceding domestic insurer.
(8) Credit must be allowed to any ceding insurer for reinsurance otherwise complying with this section only when the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer. Such credit must be allowed to the ceding insurer for reinsurance otherwise complying with this section only when the reinsurance agreement provides that payments by the assuming insurer will be made directly to the ceding insurer or its receiver, except when:
(a) The reinsurance contract specifically provides payment to the named insured, assignee, or named beneficiary of the policy issued by the ceding insurer in the event of the insolvency of the ceding insurer; or
(b) The assuming insurer, with the consent of the named insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer in substitution for the obligations of the ceding insurer to the named insured.
(9) No person, other than the ceding insurer, has any rights against the reinsurer which are not specifically set forth in the contract of reinsurance or in a specific written, signed agreement between the reinsurer and the person.

(10) An authorized insurer may not knowingly accept as assuming reinsurer any risk covering subject of insurance which is resident, located, or to be performed in this state and which is written directly by any insurer not then authorized to transact such insurance in this state, other than as to surplus lines insurance lawfully written under part VIII of chapter 626.

(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:

1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.

(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.

(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.

(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.

(12) If the office finds that a reinsurance agreement creates a substantial risk of insolvency to either insurer entering into the reinsurance agreement, the office may by order require a cancellation of the reinsurance agreement.

(13) No credit shall be allowed for reinsurance with regard to which the reinsurance agreement does not create a meaningful transfer of risk of loss to the reinsurer.
(14) The commission may adopt rules implementing the provisions of this section. Rules are authorized to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. These rules shall be in substantial compliance with:
(a) The National Association of Insurance Commissioners model regulations relating to credit for reinsurance;
(b) The National Association of Insurance Commissioners Accounting Practices and Procedures Manual as of March 2002 and subsequent amendments thereto if the methodology remains substantially consistent; and
(c) The National Association of Insurance Commissioners model regulation for Credit for Reinsurance and Life and Health Reinsurance Agreements.

The commission may further adopt rules to provide for transition from existing requirements for the approval of reinsurers to the accreditation of reinsurers pursuant to this section.

(15) Any reinsurer approved pursuant to s. 624.610(3)(a)2., as such provision existed prior to July 1, 2000, which fails to obtain accreditation pursuant to this section prior to December 30, 2003, shall have its approval terminated by operation of law on that date.
(16) This act shall apply to all cessions on or after January 1, 2001, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 2001.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.317 Investigation of agents, adjusters, administrators, service companies, and others.—If it has reason to believe that any person has violated or is violating any provision of this code, or upon the written complaint signed by any interested person indicating that any such violation may exist:
(1) The department shall conduct such investigation as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of any general agent, surplus lines agent, adjuster, managing general agent, insurance agent, insurance agency, customer representative, service representative, or other person subject to its jurisdiction, subject to the requirements of s. 626.601.
(2) The office shall conduct such investigation as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of any:
(a) Administrator, service company, or other person subject to its jurisdiction.
(b) Person having a contract or power of attorney under which she or he enjoys in fact the exclusive or dominant right to manage or control an insurer.
(c) Person engaged in or proposing to be engaged in the promotion or formation of:
1. A domestic insurer;
2. An insurance holding corporation; or
3. A corporation to finance a domestic insurer or in the production of the domestic insurer's business.

625.82 Rules.—The commission may adopt such rules as are necessary for the execution of the functions vested in it by ss. 625.75-625.81 and may for such purpose classify domestic stock insurers, securities, and other persons or matters within its jurisdiction. No provision of ss. 625.75-625.77 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule of the commission, notwithstanding that such rule may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

625.76 Preventing unfair use of information; insurer to recover profit by suit.—
(1) Any profit realized by a person required to report pursuant to s. 625.75 from any purchase and sale, or sale and purchase, within a period of less than 6 months, of any

equity security of an insurer named in such report shall inure to and be recoverable by the insurer, unless such security was acquired in good faith in connection with a debt contracted prior to the establishment of the relationship to the insurer reported under s. 625.75.
(2) Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer, or by the owner of any security of the insurer in the name and in behalf of the insurer if the insurer fails or refuses to bring such suit within 60 days after request or fails diligently to prosecute the same thereafter.
(3) This section shall not be construed to cover any transaction by a person who was not required both at the time of purchase and of sale to comply with s. 625.75.

625.55 Custodial arrangements.—
(1) In lieu of a deposit being made with it in fact, the department in its discretion may permit or require that the deposit be made with and held by the trust department of a national bank organized and existing under the laws of the United States Government or a state bank or savings and loan organized and existing under the laws of this state, provided that the national or state bank or the savings and loan is approved by the department for this purpose and under custodial arrangements likewise approved by the department, which arrangements may include the use of the Federal Reserve book-entry system or depository trust clearing systems established to hold and transfer securities by computerized book-entry systems.
(2) All such custodial arrangements shall comply in substance with the requirements of this code as to like deposits with the department of other insurers; as to the amount, purposes, maintenance, replenishment, release, and withdrawal of such deposits or part thereof; as to the rights of the insurer therein; and in all other respects except as to actual custody.
(3) The form and terms of all such custodial agreements shall be as prescribed or approved by the department consistent with the applicable provisions of this code.
(4) The compensation and expenses of any such custodian shall be borne by the insurer.
(5) The department or office may at any time, in its discretion, terminate any such custodial arrangement and require the deposit represented thereby to be made with it directly as otherwise provided for under this code.

628.511 Ownership or transfer of securities without physical delivery of certificates.—
(1) The purpose of this section is to authorize domestic insurers to use modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate rules of the commission.
(2) The following terms are defined for use in this section:
(a) "Securities" means instruments as defined in s. 678.1021.
(b) "Clearing corporation" means a clearing corporation as defined in s. 678.1021 and includes the Treasury/Reserve Automated Debt Entry System or Treasury Direct book-entry securities systems as established pursuant to 31 U.S.C. chapter 31, 12 U.S.C. s. 391, and 5 U.S.C. s. 301.
(c) "Custodian" means a national bank, state bank, trust company, broker, or dealer that participates in a clearing corporation.
(3) Notwithstanding any other provision of law, a domestic insurer may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any

custodian through which an insurer holds securities in a clearing corporation shall at all times show that such securities are held for such insurer and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation without physical delivery of certificates representing such securities.
(4) The commission may adopt rules governing the deposit by insurers of securities with clearing corporations.

628.535 Authority to adopt rules.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter.

628.801 Insurance holding companies; registration; regulation.—
(1) An insurer that is authorized to do business in this state and that is a member of an insurance holding company shall, on or before April 1 of each year, register with the office and file a registration statement and be subject to regulation with respect to its relationship to the holding company as provided by law or rule. The commission shall adopt rules establishing the information and statement form required for registration and the manner in which registered insurers and their affiliates are regulated. The rules apply to domestic insurers, foreign insurers, and commercially domiciled insurers, except for foreign insurers domiciled in states that are currently accredited by the NAIC. Except to the extent of any conflict with this code, the rules must include all requirements and standards of ss. 4 and 5 of the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation of the NAIC, as adopted in December 2010. The commission may adopt subsequent amendments thereto if the methodology remains substantially consistent. The rules may include a prohibition on oral contracts between affiliated entities. Material transactions between an insurer and its affiliates shall be filed with the office as provided by rule.
(2) Effective January 1, 2015, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report on or before April 1. As used in this subsection, the term "ultimate controlling person" means a person who is not controlled by any other person. The report, to the best of the ultimate controlling person's knowledge and belief, must identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state office of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC and is confidential and exempt from public disclosure as provided in s. 624.4212.
(a) An insurer may satisfy this requirement by providing the office with the most recently filed parent corporation reports that have been filed with the Securities and Exchange Commission which provide the appropriate enterprise risk information.
(b) The term "enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer which, if not remedied promptly, are likely to have a materially adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in s. 624.4085 or would cause the insurer to be in a hazardous financial condition.
(3) Effective January 1, 2015, pursuant to chapter 624 relating to the examination of insurers, the office may examine any insurer registered under this section and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.
(4) The filings and related documents filed pursuant to this section are confidential and exempt as provided in s. 624.4212 and are not subject to subpoena or discovery directly

from the office. A waiver of any applicable privilege or claim of confidentiality in the filings and related documents may not occur as a result of any disclosure to the office under this section or any other section of the insurance code as authorized under s. 624.4212. Neither the office nor any person who received the filings and related documents while acting under the authority of the office or with whom such information is shared pursuant to s. 624.4212 is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to s. 624.4212. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office.
(5) Effective January 1, 2015, the failure to file a registration statement, or a summary of the registration statement, or the enterprise risk filing report required by this section within the time specified for filing is a violation of this section.
(6) Upon request, the office may waive the filing requirements of this section:
(a) If the insurer is a domestic insurer that is the subsidiary of an insurer that is in full compliance with the insurance holding company registration laws of its state of domicile, which state is accredited by the NAIC; or
(b) If the insurer is a domestic insurer that writes only in this state and has annual direct written and assumed premium of less than $300 million, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, and demonstrates that compliance with this section would not provide substantial regulatory or consumer benefit. In evaluating a waiver request made under this paragraph, the office may consider various factors including, but not limited to, the type of business entity, the volume of business written, the ownership or organizational structure of the entity, or whether the company is in runoff.
A waiver granted pursuant to this subsection is valid for 2 years unless sooner withdrawn due to a change in the circumstances under which the waiver was granted.

628.152 Domestic stock insurers; proxies, consents, and authorizations with respect to any voting security.—
(1) The commission may, by rule, prescribe the form, content, and manner of solicitation of any proxy, consent, or authorization with respect to any voting security issued by a domestic stock insurer, as may be necessary or appropriate in the public interest or for the proper protection of investors in the voting securities issued by such insurer or to ensure the fair dealing in such voting securities.
(2) No person and no domestic stock insurer or any director, officer, or employee of such insurer shall solicit or permit the use of his or her name to solicit, by mail or otherwise, any person to give any proxy, consent, or authorization with respect to any voting security in contravention of any such rule.
(3) Any proxy or consent obtained in violation of this section is void. The domestic stock insurer, any stockholder of record, or the office may enforce compliance with this section, by an appropriate civil action.
(4) This section shall not apply to voting securities registered pursuant to s. 12 of the Securities Exchange Act of 1934, as amended.
(5) "Voting security" means any instrument which, in law or by contract, gives the holder the right to vote, consent to, or authorize any corporate action.

628.251 Management and exclusive agency contracts.—
(1) No domestic mutual insurer or stock insurer shall make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce

substantially all insurance business for the insurer, unless the contract is filed with and approved by the office.
(2) Any such contract shall provide that any such manager or producer of its business shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, including the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.
(3) The office shall disapprove any such contract if it finds that it:
(a) Subjects the insurer to excessive charges;
(b) Is to extend for an unreasonable length of time;
(c) Does not contain fair and adequate standards of performance; or
(d) Contains other inequitable provision or provisions which impair the proper interests of policyholders or members of the insurer.

628.371 Dividends to stockholders.—
(1) A domestic stock insurer shall not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains.
(2) Dividend payments or distributions to stockholders, without prior written approval of the office, shall not exceed the larger of:
(a) The lesser of 10 percent of surplus or net gain from operations (life and health companies) or net income (property and casualty companies), not including realized capital gains, plus a 2-year carryforward for property and casualty companies;
(b) Ten percent of surplus, with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains;
(c) The lesser of 10 percent of surplus or net investment income (net gain before capital gains for life and health companies) plus a 3-year carryforward (2-year carryforward for life and health companies) with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains.
(3) In lieu of the provisions in subsection (2), an insurer may pay a dividend or make a distribution without the prior written approval of the office when:
(a) The dividend is equal to or less than the greater of:
1. Ten percent of the insurer's surplus as to policyholders derived from realized net operating profits on its business and net realized capital gains; or
2. The insurer's entire net operating profits and realized net capital gains derived during the immediately preceding calendar year; and
(b) The insurer will have surplus as to policyholders equal to or exceeding 115 percent of the minimum required statutory surplus as to policyholders after the dividend or distribution is made; and
(c) The insurer has filed notice with the office at least 10 business days prior to the dividend payment or distribution, or such shorter period of time as approved by the office on a case-by-case basis. Such notice shall not create a right in the office to approve or disapprove a dividend otherwise properly payable hereunder; and
(d) The notice includes a certification by an officer of the insurer attesting that after payment of the dividend or distribution the insurer will have at least 115 percent of required statutory surplus as to policyholders.
(4) The office shall not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless, considering the following factors, it determines that the distribution or dividend would not jeopardize the financial condition of the insurer:
(a) The liquidity, quality, and diversification of the insurer's assets and the effect on its ability to meet its obligations.

(b) Reduction of investment portfolio and investment income.
(c) Effects on the written premium to surplus ratios as required by the Florida Insurance Code.
(d) Industrywide financial conditions.
(e) Prior dividend distributions of the insurer.
(f) Whether the dividend is only a "pass-through" dividend from a subsidiary of the insurer.
(5) A dividend or distribution by a not-for-profit insurance company subsidiary to its mutual insurance holding company, directly or indirectly through one or more intermediate holding companies, pursuant to part III of this chapter, which meets the requirements of this section and which applies to a stock insurer, is permitted under this section.

628.381 Dividends to mutual policyholders.—
(1) The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings and net realized earnings in excess of the surplus required by law to be maintained.
(2) A dividend otherwise proper may be payable out of such savings and earnings even though the insurer's total surplus is then less than the aggregate of its contributed surplus.

628.461 Acquisition of controlling stock.—
(1) A person may not, individually or in conjunction with any affiliated person of such person, acquire directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire 10 percent or more of the outstanding voting securities of a domestic stock insurer or of a controlling company, unless:
(a) The person or affiliated person has filed with the office and sent to the insurer and controlling company a letter of notification regarding the transaction or proposed transaction within 5 days after any form of tender offer or exchange offer is proposed, or within 5 days after the acquisition of the securities if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office the statement as specified in subsection (3). The statement must be completed and filed within 30 days after:
1. Any definitive acquisition agreement is entered;
2. Any form of tender offer or exchange offer is proposed; or
3. The acquisition of the securities, if no definitive acquisition agreement, tender offer, or exchange offer is involved; and
(c) The office has approved the tender or exchange offer, or acquisition if no tender offer or exchange offer is involved, and approval is in effect.

A filing required under this subsection must be made for any acquisition that equals or exceeds 10 percent of the outstanding voting securities.

(2) This section does not apply to any acquisition of voting securities of a domestic stock insurer or of a controlling company by any person who, on July 1, 1976, is the owner of a majority of such voting securities or who, on or after July 1, 1976, becomes the owner of a majority of such voting securities with the approval of the office under this section. The person or affiliated person filing the notice required by paragraph (1)(a) may request, in writing, the office to waive the requirements of paragraph (1)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the insurer.

The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the insurer.
(3) The statement to be filed with the office under subsection (1) and furnished to the insurer and controlling company must contain all the following information and any additional information that the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the policyholders and shareholders of the insurer and the public:
(a) The identity of, and the background information specified in subsection (4) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and, if the acquisition is to be made by, or on behalf of, a corporation, association, or trust, as to the corporation, association, or trust and as to any person who controls, directly or indirectly, the corporation, association, or trust, the identity of, and the background information specified in subsection (4) on, each director, officer, trustee, or other natural person performing duties similar to those of a director, officer, or trustee for the corporation, association, or trust.
(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.
(4)(a) The information as to the background and identity of each person, which information is required to be furnished pursuant to paragraph (3)(a), shall include:
1. The person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or other organization in which each such office of the person was held or in which each such occupation or position of employment was carried on.
3. Whether the person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the person has been the subject of any proceeding under the federal Bankruptcy Act or whether, during the 10-year period, any corporation,

partnership, firm, trust, or association in which the person was a director, officer, trustee, partner, or other official has been subject to any such proceeding, either during the time in which the person was a director, officer, trustee, partner, or other official or within 12 months thereafter.

6. Whether, during the 10-year period, the person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law 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, together with details as to any such event.

(b) Any corporation, association, or trust filing the statement required by this section shall give all required information that is within the knowledge of the directors, officers, or trustees (or others performing functions similar to those of a director, officer, or trustee) of the corporation, association, or trust making the filing and of any person controlling either directly or indirectly such corporation, association, or trust. A copy of the statement and any amendments to the statement shall be sent by registered mail to the insurer at its principal office within the state and to any controlling company at its principal office. If any material change occurs in the facts set forth in the statement filed with the office and sent to such insurer or controlling company pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office and sent immediately to such insurer and controlling company.

(5)(a) The acquisition of voting securities shall be deemed approved unless the office disapproves the proposed acquisition within 90 days after the statement required by subsection (1) has been filed. The office may on its own initiate, or if requested to do so in writing by a substantially affected party shall conduct, a proceeding to consider the appropriateness of the proposed filing. The 90-day time period shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time that it finds an immediate danger to the public health, safety, and welfare of the domestic policyholders exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition temporarily disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the insurer. A material change in the management of the insurer is any change in management involving officers or directors of the insurer or any person of the insurer or controlling company having authority to dispose of or obligate 5 percent or more of the insurer's capital or surplus. The office shall approve a material change in operation if it finds the applicable provisions of subsection (7) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (7) have not been met and in such case the insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(6) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:
(a) Willfully violates this section;
(b) In violation of an order of the office issued pursuant to subsection (10), fails to divest himself or herself of any stock obtained in violation of this section, or fails to divest himself or herself of any direct or indirect control of such stock, within 25 days after such order; or
(c) In violation of an order issued by the office pursuant to subsection (10), acquires additional stock of the domestic insurance company or controlling company, or direct or indirect control of such stock, without complying with this section.
(7) The person or persons filing the statement required by subsection (1) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed statement if no proceeding is conducted, that:
(a) Upon completion of the acquisition, the domestic stock insurer will be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;
(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the insurer or prejudice the interests of its policyholders or the public;
(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:
1. To liquidate the insurer, sell 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; or
2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the insurer

is fair and free of prejudice to the policyholders of the domestic stock insurer or to the public;

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the domestic stock insurer indicate that the acquisition is in the best interest of the policyholders of the insurer and in the public interest;
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the policyholders of the domestic stock insurer, and in the public interest, to permit such persons to exercise control over such domestic stock insurer;
(f) The officers and directors to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation;
(g) The management of the insurer after the acquisition will be competent and trustworthy and will possess sufficient managerial experience so as to make the proposed operation of the insurer not hazardous to the insurance-buying public;
(h) The management of the insurer after the acquisition will not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto;
(i) The acquisition is not likely to be hazardous or prejudicial to the insurer's policyholders or the public; and
(j) The effect of the acquisition of control would not substantially lessen competition in insurance in this state or would not tend to create a monopoly therein.
(8) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition of any security contrary to the provisions of this section is void. Upon the petition of the domestic stock insurer or controlling company, the circuit court for the county in which the principal office of such domestic stock insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the

provisions of this section. There shall be a private right of action in favor of the domestic stock insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the domestic stock insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by such domestic stock insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of a statement pursuant to this section, or who files such a statement, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section, and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.

(9) Any approval by the office under this section does not constitute a recommendation by the office for an acquisition, tender offer, or exchange offer. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.

(10) Upon notification to the office by the domestic stock insurer or a controlling company that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of the domestic stock insurer or controlling company without complying with the provisions of this section, the office shall order that the person and any affiliated person of such person cease acquisition of any further securities of the domestic stock insurer or controlling company; however, the person or any affiliated person of such person may request a proceeding, which proceeding shall be convened within 7 days after the rendering of the order for the sole purpose of determining whether the person, individually or in connection with any affiliated person of such person, has acquired 10 percent or more of the outstanding voting securities of a domestic stock insurer or controlling company. Upon the failure of the person or affiliated person to request a hearing within 7 days, or upon a determination at a hearing convened pursuant to this subsection that the person or affiliated person has acquired voting securities of a domestic stock insurer or controlling company in violation of this section, the office may order the person and affiliated person to divest themselves of any voting securities so acquired.

(11)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any insurer or controlling company:

1. The control of which is acquired in violation of this section;
2. That is controlled, directly or indirectly, by any person or any affiliated person of such person who, in violation of this section, has obtained control of a domestic stock insurer or controlling company; or
3. That is controlled, directly or indirectly, by any person who, directly or indirectly, controls any other person who, in violation of this section, acquires control of a domestic stock insurer or controlling company.

(b) If any insurer is subject to suspension or revocation pursuant to paragraph (a), the insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, creditors, or stockholders or to the public.

(12)(a) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the office. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to rules 13d-1(b) or 13d-1(c) under the Securities Exchange Act of 1934, as

amended. After a disclaimer has been filed, the insurer is relieved of any duty to register or report under this section which may arise out of the insurer's relationship with the person unless the office disallows the disclaimer.
(b) A controlling person of a domestic insurer who seeks to divest the person's controlling interest in the domestic insurer in any manner shall file with the office, with a copy provided to the insurer, confidential notice, not subject to public inspection as provided under s. 624.4212, of the person's proposed divestiture at least 30 days before the cessation of control. The office shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer must file for and obtain approval of the transaction. The information remains confidential until the conclusion of the transaction unless the office, in its discretion, determines that confidential treatment interferes with enforcement of this section. If the statement referred to in subsection (1) is otherwise filed, this paragraph does not apply.
(13) The commission may adopt rules that are necessary to administer this section.

628.801 Insurance holding companies; registration; regulation.—
(1) An insurer that is authorized to do business in this state and that is a member of an insurance holding company shall, on or before April 1 of each year, register with the office and file a registration statement and be subject to regulation with respect to its relationship to the holding company as provided by law or rule. The commission shall adopt rules establishing the information and statement form required for registration and the manner in which registered insurers and their affiliates are regulated. The rules apply to domestic insurers, foreign insurers, and commercially domiciled insurers, except for foreign insurers domiciled in states that are currently accredited by the NAIC. Except to the extent of any conflict with this code, the rules must include all requirements and standards of ss. 4 and 5 of the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation of the NAIC, as adopted in December 2010. The commission may adopt subsequent amendments thereto if the methodology remains substantially consistent. The rules may include a prohibition on oral contracts between affiliated entities. Material transactions between an insurer and its affiliates shall be filed with the office as provided by rule.
(2) Effective January 1, 2015, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report on or before April 1. As used in this subsection, the term "ultimate controlling person" means a person who is not controlled by any other person. The report, to the best of the ultimate controlling person's knowledge and belief, must identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state office of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC and is confidential and exempt from public disclosure as provided in s. 624.4212.
(a) An insurer may satisfy this requirement by providing the office with the most recently filed parent corporation reports that have been filed with the Securities and Exchange Commission which provide the appropriate enterprise risk information.
(b) The term "enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer which, if not remedied promptly, are likely to have a materially adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in s. 624.4085 or would cause the insurer to be in a hazardous financial condition.
(3) Effective January 1, 2015, pursuant to chapter 624 relating to the examination of insurers, the office may examine any insurer registered under this section and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the

insurance holding company system, or by the insurance holding company system on a consolidated basis.
(4) The filings and related documents filed pursuant to this section are confidential and exempt as provided in s. 624.4212 and are not subject to subpoena or discovery directly from the office. A waiver of any applicable privilege or claim of confidentiality in the filings and related documents may not occur as a result of any disclosure to the office under this section or any other section of the insurance code as authorized under s. 624.4212. Neither the office nor any person who received the filings and related documents while acting under the authority of the office or with whom such information is shared pursuant to s. 624.4212 is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to s. 624.4212. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office.
(5) Effective January 1, 2015, the failure to file a registration statement, or a summary of the registration statement, or the enterprise risk filing report required by this section within the time specified for filing is a violation of this section.
(6) Upon request, the office may waive the filing requirements of this section:
(a) If the insurer is a domestic insurer that is the subsidiary of an insurer that is in full compliance with the insurance holding company registration laws of its state of domicile, which state is accredited by the NAIC; or
(b) If the insurer is a domestic insurer that writes only in this state and has annual direct written and assumed premium of less than $300 million, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, and demonstrates that compliance with this section would not provide substantial regulatory or consumer benefit. In evaluating a waiver request made under this paragraph, the office may consider various factors including, but not limited to, the type of business entity, the volume of business written, the ownership or organizational structure of the entity, or whether the company is in runoff.
A waiver granted pursuant to this subsection is valid for 2 years unless sooner withdrawn due to a change in the circumstances under which the waiver was granted.

628.803 Sanctions.—
(1) Any company failing, without just cause, to file any registration statement or certificate of exemption required to be filed pursuant to commission rules relating to this part or to submit an ORSA summary report or a corporate governance annual disclosure required pursuant to s. 628.8015 shall, in addition to other penalties prescribed under the Florida Insurance Code, be subject to pay a penalty of $100 for each day's delay, not to exceed a total of $10,000.
(2) Every director or officer of an insurance holding company system who knowingly violates or participates in, or who knowingly directs any of the officers or agents of the company to engage in transactions or make investments which have not been properly filed or approved or which violate commission rules relating to this part, shall pay, in their individual capacity, a civil forfeiture of not more than $5,000 per violation. In determining the amount of the civil forfeiture, the office shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, and the history of previous violations.
(3) Whenever it appears to the office that any insurer subject to this part or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which violates commission rules relating to this part, the office may order the insurer to cease and desist immediately any further activity under that transaction or contract. The office may also order the insurer to void any such transaction or contract and

restore the status quo if this action is in the best interest of the policyholders, creditors, or public.

[1](4) If the office determines that any person violated s. 628.461, s. 628.801, or s. 628.8015, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with part VI of chapter 624.

(5) Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to, or makes or causes to be made, any false statements, false reports, or false filings with the intent to deceive the office in the performance of its duties under this part is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

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634.302 Powers of department, commission, and office; rules.—The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to home warranty associations and home warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.336 but shall not enlarge upon or extend the provisions of that section.

634.308 Grounds for suspension or revocation of license.—
(1) The license of any home warranty association may be revoked or suspended, or the office may refuse to renew any such license, if it is determined that:
(a) The association has violated any lawful rule or order of the commission or office or any provision of this part.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with

information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

634.304 Qualifications for license.—The office may not issue or renew a license to any home warranty association unless the association:
(1) Is a solvent corporation formed under the laws of this state or of another state, district, territory, or possession of the United States.
(2) Furnishes the office with evidence satisfactory to it that the management of the association is competent and trustworthy and can successfully manage the affairs of the association in compliance with law.
(3) Proposes to use and uses in its business a name, together with a trademark or emblem, if any, which is distinctive and not so similar to the name or trademark of any other association, corporation, or organization already doing business in this state as will tend to mislead or confuse the public.
(4) Meets the deposit requirements under s. 634.305.
(5) Is otherwise in compliance with this part.

634.306 Application for and issuance of license.—
(1) An application for license as a home warranty association must be made to and must be filed with the office on printed forms prescribed by the commission and furnished by the office.
(2) In addition to information relative to its qualifications as required under s. 634.304, the application must show:
(a) The location of the applicant's home office.

(b) The name and residence address of each director or officer of the applicant and the name and residence address of each shareholder who owns or controls 10 percent or more shares of the applicant.
(c) Such other pertinent information as is required by the office or commission.
(3) The application must be accompanied by:
(a) A copy of the applicant's articles of incorporation, certified by the public official having custody of the original, and a copy of the applicant's bylaws, certified by the applicant's secretary.
(b) A copy of the most recent financial statement of the applicant, verified under oath of at least two of its principal officers.
(c) A license fee in the amount of $200, as required under s. 634.303.
(4) Upon completion of the application for license, the office shall examine the application and make any further investigation of the applicant as it deems advisable. If it finds that the applicant is qualified therefor, the office shall issue to the applicant a license as a home warranty association. If the office does not so find, it shall refuse to issue the license and shall give the applicant written notice of such refusal, setting forth the grounds therefor.

634.307 License expiration; renewal.—Each license as a home warranty association issued under this part shall expire on June 1 next following the date of issuance. If the association is then qualified therefor under the provisions of this part, its license may be renewed annually, upon its request and upon payment to the office of the license tax in the amount of $200, in advance, for each such license year.

634.3073 Acquisition.—Every home warranty association shall be subject to the provisions of s. 628.4615.

634.3077 Financial requirements.—
(1) An association licensed under this part shall maintain a funded, unearned premium reserve account, consisting of unencumbered assets, equal to a minimum of 25 percent of the gross written premiums received by it from all warranty contracts in force. Such assets shall be held in the form of cash or invested in securities for investments as provided in part II of chapter 625.
(2) An association shall maintain, at a minimum, net assets equal to one-sixth of the written premiums it receives for the issuance and delivery of any binder or warranty in force. Net assets may be less than one-sixth of the premiums written provided the association has net assets of not less than $500,000 and maintains a funded, unearned premium reserve account consisting of unencumbered assets equal to a minimum of 40 percent of the gross written premiums received by it from all warranty contracts in force which shall be held in the form of cash or invested in securities for investments as provided in part II of chapter 625.
(3) An association shall not be required to set up an unearned premium reserve if it has purchased contractual liability insurance which demonstrates to the satisfaction of the office that 100 percent of its claim exposure is covered by such insurance. Such contractual liability insurance shall be obtained from an insurer that holds a certificate of authority to do business within the state or from an insurer approved by the office as financially capable of meeting the obligations incurred pursuant to the policy. For purposes of this subsection, the contractual liability policy shall contain the following provisions:
(a) In the event that the home warranty association is unable to fulfill its obligation under its contracts issued in this state for any reason, including insolvency, bankruptcy, or dissolution, the contractual liability insurer will pay losses and unearned premiums under such plans directly to persons making claims under such contracts.

(b) The insurer issuing the policy shall assume full responsibility for the administration of claims in the event of the inability of the association to do so.
(c) The policy may not be canceled or not renewed by either the insurer or the association unless 60 days' written notice thereof has been given to the office by the insurer before the date of such cancellation or nonrenewal.
(d) The contractual liability insurance policy shall insure all home warranty contracts that were issued while the policy was in effect whether or not the premium has been remitted to the insurer.
(4) An association that purchases contractual liability insurance on the warranties that it issues shall provide the office with claim statistics required to be filed by associations not purchasing such insurance.

634.313 Tax on premiums; annual statement; reports.—
(1) In addition to paying the license taxes provided for in this part for home warranty associations and license taxes provided in the insurance code as to insurers, each such association and each such insurer must, annually on or before March 1, file with the office its annual statement, in the form prescribed by the commission, showing all premiums received by it in connection with the issuance of warranties in this state during the preceding calendar year and using accounting principles that will enable the office to ascertain whether the reserve required by s. 634.3077 has been maintained. Each annual statement must contain a balance sheet listing all assets and liabilities; a statement of operations and retained earnings; and a schedule used to report all claims statistics. The annual statement must be completed using generally accepted accounting principles except as otherwise provided in this part. Further, each association and each insurer must pay to the Chief Financial Officer a tax in an amount equal to 2 percent of the amount of such premiums so received.
(2) Premiums received by insurers and taxed under this section are not subject to any premium tax provided for in the insurance code.
(3) Any association or insurer neglecting to file the annual statement in the form and within the time provided by this section shall forfeit up to $100 for each day during which such neglect continues; and, upon notice by the office to that effect, its authority to do business in this state shall cease while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.
(4) The commission may by rule require each home warranty association to submit to the office, as the commission may designate, all or part of the information contained in the financial reports required by this section in a computer-readable form compatible with the electronic data processing system specified by the office.

634.315 Service of process.—Home warranty associations are subject to service of process in the same manner and subject to the same terms, conditions, and fees as apply to insurers under chapter 624.

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634.021 Powers of department, commission, and office; rules.—The office shall administer this act and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act related to motor vehicle service agreement companies and motor vehicle service agreements. The department shall administer this act and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this act related to sales representatives.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with

information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.501 Filing, license, appointment, and miscellaneous fees.—The department, commission, or office, as appropriate, shall collect in advance, and persons so served shall pay to it in advance, fees, licenses, and miscellaneous charges as follows:
(1) Certificate of authority of insurer.
(a) Filing application for original certificate of authority or modification thereof as a result of a merger, acquisition, or change of controlling interest due to a sale or exchange of stock, including all documents required to be filed therewith, filing fee.....$1,500.00
(b) Reinstatement fee.....$50.00
(2) Charter documents of insurer.
(a) Filing articles of incorporation or other charter documents, other than at time of application for original certificate of authority, filing fee.....$10.00
(b) Filing amendment to articles of incorporation or charter, other than at time of application for original certificate of authority, filing fee.....$5.00
(c) Filing bylaws, when required, or amendments thereof, filing fee.....$5.00
(3) Annual license tax of insurer, each domestic insurer, foreign insurer, and alien insurer (except that, as to fraternal benefit societies insuring less than 200 members in this state and the members of which as a prerequisite to membership possess a physical handicap or disability, such license tax shall
be $25).....$1,000.00
(4) Statements of insurer, filing (except when filed as part of application for original certificate of authority), filing fees:
(a) Annual statement.....$250.00

(b) Quarterly statement.....$250.00
(5) All insurance representatives, application for license, application for reinstatement of suspended license, each filing, filing fee.....$50.00
(6) Insurance representatives, property, marine, casualty, and surety insurance.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Customer representative's original appointment and biennial renewal or continuation thereof:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(d) Service representatives; managing general agents.

Original appointment and biennial renewal or continuation thereof, each insurer or managing general agent, whichever is applicable.....$60.00

(7) Life insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(8) Health insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(9)(a) Except as provided in paragraph (b), all limited appointments as agent, as provided for in s. 626.321. Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) For all limited appointments as agent, as provided in s. 626.321(1)(c) and (d), the agent's original appointment and biennial renewal or continuation thereof for each insurer is equal to the number of offices, branch offices, or places of business covered by the license multiplied by the fees set forth in paragraph (a).
(10) Fraternal benefit society agents. Original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(11) Surplus lines agent. Agent's appointment and biennial renewal or continuation thereof, appointment fee.....$150.00
(12) Adjusters:
(a) Adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(b) Nonresident adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(c) Emergency adjuster's license, appointment fee.....$10.00
(d) Fee to cover actual cost of credit report, when such report must be secured by department.
(13) Examination—Fee to cover actual cost of examination.
(14) Temporary license and appointment as agent or adjuster, where expressly provided for, rate of fee for each month of the period for which the license and appointment is issued.....$5.00

(15) Issuance, reissuance, reinstatement, modification resulting in a modified license being issued, duplicate copy of any insurance representative license, or an appointment being reinstated.....$5.00
(16) Additional appointment continuation fees as prescribed in chapter 626.....$5.00
(17) Filing application for permit to form insurer as referred to in chapter 628, filing fee.....$25.00
(18) Annual license fee of rating organization, each domestic or foreign organization.....$25.00
(19) Miscellaneous services:
(a) For copies of documents or records on file with the department, commission, or office, per
page.....$ .15
(b) For each certificate of the department, commission, or office under its seal, authenticating any document or other instrument (other than a license or certificate of authority).....$5.00
(c) For preparing lists of agents, adjusters, and other insurance representatives, and for other miscellaneous services, such reasonable charge as may be fixed by the office or department.
(d) For processing requests for approval of continuing education courses, processing fee.....$100.00
(e) Insurer's registration fee for agent exchanging business more than 24 times in calendar year under s. 626.752, s. 626.793, or s. 626.837, registration fee per agent per year.....$30.00
(20) Adjusting firm, original or renewal 3-year license.....$60.00
(21) Limited surety agent or professional bail bond agent, as defined in s. 648.25, each agent and each insurer represented. Original appointment and biennial renewal or continuation thereof, each agent or insurer, whichever is applicable:

Appointment fee.....$44.00

State tax.....24.00

County tax.....12.00

Total.....$80.00

(22) Certain military installations, as authorized under s. 626.322: original appointment and biennial renewal or continuation thereof, each insurer.....$20.00
(23) Filing application for original certificate of authority for third-party administrator or original certificate of approval for a service company, including all documents required to be filed therewith, filing fee.....$100.00
(24) Fingerprinting processing fee—Fee to cover fingerprint processing.
(25) Sales representatives, miscellaneous lines. Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(27) Title insurance agents:
(a) Agent's original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Agency original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Filing for title insurance agent's license:

Application for filing, each filing, filing fee.....$10.00

(d) Additional appointment continuation fee as prescribed by s. 626.843.....$5.00
(e) Title insurer and title insurance agency administrative surcharge:
1. On or before January 30 of each calendar year, each title insurer shall pay to the office for each licensed title insurance agency appointed by the title insurer and for each retail office of the insurer on January 1 of that calendar year an administrative surcharge of $200.00.
2. On or before January 30 of each calendar year, each licensed title insurance agency shall remit to the department an administrative surcharge of $200.00.

The administrative surcharge may be used solely to defray the costs to the department and office in their examination or audit of title insurance agencies and retail offices of title insurers and to gather title insurance data for statistical purposes to be furnished to and used by the office in its regulation of title insurance.

(28) Late filing of appointment renewals for agents, adjusters, and other insurance representatives, each appointment.....$20.00

634.041 Qualifications for license.—To qualify for and hold a license to issue service agreements in this state, a service agreement company must be in compliance with this part, with applicable rules of the commission, with related sections of the Florida Insurance Code, and with its charter powers and must comply with the following:
(1) Any service agreement company applying for a license must be a solvent corporation formed under the laws of this state or of another state or district of the United States and must meet minimum requirements under this section.
(2) The service agreement company must furnish the office with evidence satisfactory to the office that the management of the company is competent and trustworthy and can successfully and lawfully manage its affairs.
(3) The service agreement company must make the deposit required under s. 634.052.

(4) A service agreement company may not be licensed to transact service agreement business in this state unless it maintains the required reserves and the required ratio of liquid assets to the required reserves.
(5) A service agreement company may not be licensed to transact service agreement business in this state if, during the 3 years immediately preceding its application for a license, it has violated any requirement of this part or a rule adopted thereunder.
(6) In order to obtain or maintain a license, a service agreement company must have and maintain minimum net assets of $500,000. However, a service agreement company that maintains a gross written premium of less than $750,000 at all times, that has been licensed in Florida for more than 5 years, and that has never had an administrative complaint filed by the office against its operations under this part may reach this net asset requirement in equal increments over a 5-year period beginning on October 1, 1991.
(7) All assets used to maintain the minimum net asset requirement must be maintained in the United States.
(8)(a) A service agreement company must establish and maintain an unearned premium reserve in accordance with the following:
1. It must consist of unencumbered assets equal to a minimum of 50 percent of the unearned gross written premium on each service agreement and must amortize this reserve pro rata over the duration of the service agreement. Such assets must be held in the form of cash or invested in securities for investment under ss. 625.301-625.340.
2. In addition to the net asset requirements set forth in subsection (6), a company utilizing the 50-percent reserve must not allow its ratio of gross written premium in force to net assets to exceed 10 to 1. For companies that have utilized both contractual liability insurance and the 50-percent reserve, this ratio must be calculated based only on that portion of gross written premium in force which is covered by the 50-percent reserve.
3. A company that uses an unearned premium reserve must deposit with the department securities of the type eligible for deposit by insurers under s. 625.52 equal to 15 percent of the unearned premium reserve. This reserve deposit may be included as an asset for calculating the requirement of subparagraph 1. A request for release of the reserve deposit may be made quarterly only after the office has approved the company's current quarterly or annual financial statement and a statement sworn to by two officers of the company, verifying that the release will not reduce the reserve deposit to less than 15 percent of the unearned premium reserve.
(b) A service agreement company does not have to establish and maintain an unearned premium reserve if it purchases and maintains contractual liability insurance in accordance with the following:
1. The insurance covers 100 percent of its claim exposure and is obtained from an insurer approved by the office which holds a certificate of authority to do business within this state.
2. If the service agreement company does not meet its contractual obligations, the contractual liability insurance policy binds its issuer to pay or cause to be paid to the service agreement holder all legitimate claims and cancellation refunds for all service agreements issued by the service agreement company while the policy was in effect. This requirement also applies to those service agreements for which no premium has been remitted to the insurer.
3. If the issuer of the contractual liability policy is fulfilling the service agreements covered by the contractual liability policy and the service agreement holder cancels the service agreement, the issuer must make a full refund of unearned premium to the consumer, subject to the cancellation fee provisions of s. 634.121(3). The sales representative and agent must refund to the contractual liability policy issuer their unearned pro rata commission.
4. The policy may not be canceled, terminated, or nonrenewed by the insurer or the service agreement company unless a 90-day written notice thereof has been given to the office by the insurer before the date of the cancellation, termination, or nonrenewal.

5. The service agreement company must provide the office with the claims statistics.

All funds or premiums remitted to an insurer by a motor vehicle service agreement company under this part shall remain in the care, custody, and control of the insurer and shall be counted as an asset of the insurer; provided, however, this requirement does not apply when the insurer and the motor vehicle service agreement company are affiliated companies and members of an insurance holding company system. If the motor vehicle service agreement company chooses to comply with this paragraph but also maintains a reserve to pay claims, such reserve shall only be considered an asset of the covered motor vehicle service agreement company and may not be simultaneously counted as an asset of any other entity.

(9)(a) In meeting the requirements of this part, except as provided in paragraph (b), a service agreement company may not utilize both the 50-percent reserve and contractual liability insurance simultaneously. However, a company may have contractual liability coverage on service agreements previously sold and sell new service agreements covered by the 50-percent reserve, and the converse of this is also allowed. A service agreement company must be able to distinguish how each individual service agreement is covered.
(b) A service agreement company that maintains net assets of at least $10 million and that annually files with the office a financial statement audited in accordance with generally accepted accounting principles may use either the 50-percent reserve or the contractual liability coverage for specific blocks of new service agreements. For purposes of this subsection, the term "specific blocks of new service agreements" means the service agreements sold by a single designated licensed salesperson. A service agreement company must be able to distinguish how each individual service agreement is covered. A service agreement company using the 50-percent premium reserve, as permitted under this subsection, must obtain contractual liability insurance coverage for any future deficits in the premium reserve account directly attributable to the specific blocks of new agreements written. Such a contractual liability insurance policy must be filed with the office. Such policies or endorsements to an existing policy must contain language evidencing that the contractual liability insurance policy shall pay claims arising out of such specific blocks of agreements if the service agreement company cannot or will not pay such claims. All contractual liability insurance policies issued to a service agreement company under this part must cover all agreements issued during the term of the policy and, for purposes of this section, the company must obtain and file with the office endorsements to that policy identifying the specific blocks of agreements not covered thereunder.
(10) In addition to information called for and furnished with its annual statement, a service agreement company must furnish to the office, as soon as reasonably possible, any information as to its transactions or affairs that the office requests in writing. All information furnished pursuant to the request of the office must be verified by the oath of two executive officers of the service agreement company.
(11)(a) A service agreement company offering service agreements providing vehicle protection expenses may meet the requirements for this part only by maintaining contractual liability insurance covering 100 percent of its vehicle protection claim exposure in accordance with paragraph (8)(b), which insurance must be issued by an insurance company not affiliated with the service agreement company, unless the insurance company had issued a contractual liability insurance policy to a service agreement company on or before January 1, 2002. Service agreements providing vehicle protection expenses may be sold only to a service agreement holder that has in-force comprehensive motor vehicle insurance coverage for the vehicle to be covered by the service agreement.
(b) Notwithstanding any other requirement of this part, a service agreement company maintaining an unearned premium reserve on all service agreements in accordance with paragraph (8)(a) may offer service agreements providing vehicle protection expenses if it maintains contractual liability insurance only on all service agreements providing vehicle

protection expenses and continues to maintain the 50-percent reserve for all service agreements not providing vehicle protection expenses. A service agreement company maintaining contractual liability insurance for all service agreements providing vehicle protection expenses and the 50-percent reserve for all other service agreements must, in the service agreement register as required under s. 634.136(2), distinguish between insured service agreements providing vehicle protection expenses and service agreements not providing vehicle protection expenses.

(12) A motor vehicle manufacturer complying with the provisions of this part must be an entity formed under the laws of this state or of another state or district of the United States and need comply only with subsections (2) and (10). A motor vehicle manufacturer need not submit fingerprints, background information, or biographical statements for any individual except those serving as officers or directors of the applicant entity. A motor vehicle manufacturer need not comply with s. 634.081(5). Motor vehicle manufacturers are subject to all other applicable provisions of this part.

634.061 Application for and issuance of license.—

(1) A sworn application for a license as a motor vehicle service agreement company shall be made to and filed with the office on forms as prescribed by the commission and furnished by the office.

(2) In addition to information relative to its qualifications as called for under s. 634.041, the application shall show:

(a) The location of the applicant's home office.

(b) The name and residence address of each director, officer, and 10-percent or greater stockholder of the applicant.

(c) Other pertinent information as required by the commission or office.

(3) The application when filed shall be accompanied by:

(a) If a corporation or partnership, a copy of the applicant's articles of incorporation or partnership document, if any, certified by the public official having custody of the original and a copy of its bylaws certified by its secretary.

(b) A copy of the most recent financial statement of the applicant, verified under the oath of at least two of its principal officers.

(c) The license tax as required under s. 634.071.

(4) Upon completion of the application for license, the office shall examine the same and make such further investigation of the applicant as it deems advisable. If it finds that the applicant is qualified therefor under this part, it shall issue to the applicant a license as a motor vehicle service agreement company. If the office does not so find, it shall refuse to issue the license.

634.071 License continuance.—A license issued under this part shall continue in force as long as the motor vehicle service agreement company is entitled thereto under this part and until suspended, revoked, or terminated. Annually, in conjunction with the March 1 filing of the annual report, each motor vehicle service agreement company shall file a $100 license fee.

634.161 Service of process; method.—

(1) Service of process upon the Chief Financial Officer as process agent of the company shall be made by serving copies in triplicate of the process upon the Chief Financial Officer. Upon receiving such service, the Chief Financial Officer shall file one copy with the department, return one copy with her or his admission of service, and promptly forward one copy of the process by registered or certified mail to the person last designated by the company to receive the same, as provided under s. 634.151.

(2) Process served upon the Chief Financial Officer and copy thereof forwarded as in this section provided shall for all purposes constitute valid and binding service thereof upon the company.

634.252 Acquisition.—Every motor vehicle service agreement company shall be subject to the provisions of s. 628.4615.

642.032 Provisions of general insurance law applicable to legal expense insurance corporations.—The following provisions of the Florida Insurance Code shall apply to legal expense insurance corporations, to the extent that they are not inconsistent with the provisions of ss. 642.011-642.049:
(1) Chapter 624, administration and general provisions.
(2) Chapter 625, accounting, investments, and deposits.
(3) Chapter 626, part IX, unfair insurance trade practices.
(4) Chapter 627, part I, rates and rating organizations, and part II, the insurance contract.
(5) Section 628.4615, specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.
(6) Chapter 631, insurer insolvency; guaranty of payment.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.610 Reinsurance.—
(1) The purpose of this section is to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. It is the intent of the Legislature to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislature requires that upon the insolvency of a non-United States insurer or reinsurer which provides security to fund its United States obligations in accordance with this section, such security shall be maintained in the United States and claims shall be filed with and valued by the state insurance regulator with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in this section are fundamental to the business of insurance in accordance with 15 U.S.C. ss. 1011-1012.
(2) Credit for reinsurance must be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (3)(a), paragraph (3)(b), or paragraph (3)(c). Credit must be allowed under paragraph (3)(a) or paragraph (3)(b) only for cessions of those kinds or lines of business that the assuming insurer is licensed, authorized, or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed or authorized to transact insurance or reinsurance.
(3)(a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is authorized to transact insurance or reinsurance in this state.
(b)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. An accredited reinsurer is one that:
a. Files with the office evidence of its submission to this state's jurisdiction;
b. Submits to this state's authority to examine its books and records;

c. Is licensed or authorized to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through, licensed, or authorized to transact insurance or reinsurance in at least one state;
d. Files annually with the office a copy of its annual statement filed with the insurance department of its state of domicile any quarterly statements if required by its state of domicile or such quarterly statements if specifically requested by the office, and a copy of its most recent audited financial statement; and
(I) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the office within 90 days after its submission; or
(II) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has been approved by the office.
2. The office may deny or revoke an assuming insurer's accreditation if the assuming insurer does not submit the required documentation pursuant to subparagraph 1., if the assuming insurer fails to meet all of the standards required of an accredited reinsurer, or if the assuming insurer's accreditation would be hazardous to the policyholders of this state. In determining whether to deny or revoke accreditation, the office may consider the qualifications of the assuming insurer with respect to all the following subjects:
a. Its financial stability;
b. The lawfulness and quality of its investments;
c. The competency, character, and integrity of its management;
d. The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer; and
e. Whether claims under its contracts are promptly and fairly adjusted and are promptly and fairly paid in accordance with the law and the terms of the contracts.
3. Credit must not be allowed a ceding insurer if the assuming insurer's accreditation has been revoked by the office after notice and the opportunity for a hearing.
4. The actual costs and expenses incurred by the office to review a reinsurer's request for accreditation and subsequent reviews must be charged to and collected from the requesting reinsurer. If the reinsurer fails to pay the actual costs and expenses promptly when due, the office may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.
(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (5)(b), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.
2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:
(I) The insurance regulator of the state in which the trust is domiciled; or
(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.
b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.
c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than

February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.
3. The following requirements apply to the following categories of assuming insurer:
a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.
b.(I) In the case of a group including incorporated and individual unincorporated underwriters:
(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust consists of a trusteed 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;
(B) 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 section, the trust consists of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and
(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.
(II) The incorporated members of the group must not be engaged in any business other than underwriting of a member of the group, and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as the unincorporated members.
(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.
(d) Credit must be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), or paragraph (c), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required to be purchased by a particular entity by applicable law or regulation of that jurisdiction.
(e) If the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), paragraph (c), or paragraph (d), the commissioner may allow credit, but only if the assuming insurer holds surplus in excess of $250 million and has a secure financial strength rating from at least two statistical rating organizations deemed acceptable by the commissioner as having experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Service, Fitch Ratings, A.M. Best Company, and Demotech. In determining whether credit should be allowed, the commissioner shall consider the following:
1. The domiciliary regulatory jurisdiction of the assuming insurer.
2. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and the financial surveillance of the reinsurer.

3. The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction.
4. The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles.
5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the office in particular.
6. The history of performance by reinsurers in the domiciliary jurisdiction.
7. Any documented evidence of substantial problems with the enforcement of valid United States judgments in the domiciliary jurisdiction.
8. Any other matters deemed relevant by the commissioner. The commissioner shall give appropriate consideration to insurer group ratings that may have been issued. The commissioner may, in lieu of granting full credit under this subsection, reduce the amount required to be held in trust under paragraph (c).
(f) If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state pursuant to paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) must not be allowed unless the assuming insurer agrees in the reinsurance agreements:
1.a. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and
b. To designate the Chief Financial Officer, pursuant to s. 48.151, or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.
2. This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.
(g) If the assuming insurer does not meet the requirements of paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) is not allowed unless the assuming insurer agrees in the trust agreements, in substance, to the following conditions:
1. 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 paragraph (c), 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 United States court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight all of the assets of the trust fund.
2. The assets must be distributed by and claims must be filed with and valued by the insurance regulator with regulatory oversight in accordance with the laws of the state in which the trust is domiciled which are applicable to the liquidation of domestic insurance companies.
3. If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof must be returned by the insurance regulator with regulatory oversight to the trustee for distribution in accordance with the trust agreement.
4. The grantor shall waive any right otherwise available to it under United States law which is inconsistent with this provision.

(4) An asset allowed or a deduction from liability taken for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of subsections (2) and (3) is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The deduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (5)(b). This security may be in the form of:
(a) Cash in United States dollars;
(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets pursuant to part II of chapter 625;
(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or
(d) Any other form of security acceptable to the office.
(5)(a) For purposes of paragraph (4)(c) regarding letters of credit, a "qualified United States financial institution" means an institution that:
1. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state thereof;
2. Is regulated, supervised, and examined by United States or state authorities having regulatory authority over banks and trust companies; and
3. Has been determined by either the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the office.
(b) For purposes of those provisions of this law which specify institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that is a member of the Federal Reserve System or that has been determined by the office to meet the following criteria:
1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and
2. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.
(6) For the purposes of this section only, the term "ceding insurer" includes any health maintenance organization operating under a certificate of authority issued under part I of chapter 641.
(7) After notice and an opportunity for a hearing, the office may disallow any credit that it finds would be contrary to the proper interests of the policyholders or stockholders of a ceding domestic insurer.
(8) Credit must be allowed to any ceding insurer for reinsurance otherwise complying with this section only when the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer. Such credit must be allowed to the ceding insurer for reinsurance otherwise complying with this section only when the reinsurance agreement provides that payments by the assuming insurer will be made directly to the ceding insurer or its receiver, except when:
(a) The reinsurance contract specifically provides payment to the named insured, assignee, or named beneficiary of the policy issued by the ceding insurer in the event of the insolvency of the ceding insurer; or

(b) The assuming insurer, with the consent of the named insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer in substitution for the obligations of the ceding insurer to the named insured.
(9) No person, other than the ceding insurer, has any rights against the reinsurer which are not specifically set forth in the contract of reinsurance or in a specific written, signed agreement between the reinsurer and the person.
(10) An authorized insurer may not knowingly accept as assuming reinsurer any risk covering subject of insurance which is resident, located, or to be performed in this state and which is written directly by any insurer not then authorized to transact such insurance in this state, other than as to surplus lines insurance lawfully written under part VIII of chapter 626.
(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:
1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.
(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.
(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.
(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.
(12) If the office finds that a reinsurance agreement creates a substantial risk of insolvency to either insurer entering into the reinsurance agreement, the office may by order require a cancellation of the reinsurance agreement.
(13) No credit shall be allowed for reinsurance with regard to which the reinsurance agreement does not create a meaningful transfer of risk of loss to the reinsurer.
(14) The commission may adopt rules implementing the provisions of this section. Rules are authorized to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. These rules shall be in substantial compliance with:
(a) The National Association of Insurance Commissioners model regulations relating to credit for reinsurance;
(b) The National Association of Insurance Commissioners Accounting Practices and Procedures Manual as of March 2002 and subsequent amendments thereto if the methodology remains substantially consistent; and
(c) The National Association of Insurance Commissioners model regulation for Credit for Reinsurance and Life and Health Reinsurance Agreements.

The commission may further adopt rules to provide for transition from existing requirements for the approval of reinsurers to the accreditation of reinsurers pursuant to this section.

(15) Any reinsurer approved pursuant to s. 624.610(3)(a)2., as such provision existed prior to July 1, 2000, which fails to obtain accreditation pursuant to this section prior to December 30, 2003, shall have its approval terminated by operation of law on that date.
(16) This act shall apply to all cessions on or after January 1, 2001, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 2001.

624.80 Definitions.—As used in this part:
(1) "Insurer" means and includes every person as defined in s. 624.03 as limited to:
(a) Any domestic or commercially domiciled insurer who is doing business as an insurer, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.
(b) Any specialty insurer as that term is defined in s. 628.4615.
(c) Any domestic or commercially domiciled fraternal benefit society which is subject to the provisions of chapter 632.
(2) "Unsound condition" means that the office has determined that one or more of the following conditions exist with respect to an insurer:
(a) The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
(b) The insurer continues to write new business when it has not maintained the required surplus or capital;
(c) The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the office, for liabilities arising from insurance policies issued by the insurer; or
(d) The insurer meets one or more of the grounds in s. 631.051 for the appointment of the department as receiver.
(3) "Exceeded its powers" means the following conditions:
(a) The insurer has refused to permit examination by the office of its books, papers, accounts, records, or business practices;
(b) An insurer organized in this state has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer by the office;

(c) The insurer has failed to promptly comply with the applicable financial reporting statutes and office requests relating thereto;
(d) The insurer has neglected or refused to observe an order of the office to correct a deficiency in its capital or surplus; or
(e) The insurer has unlawfully or in violation of an office order:
1. Totally reinsured its entire outstanding business; or
2. Merged or consolidated substantially its entire property or business with another insurer.
(4) "Consent" means authorized written agreement to supervision by the insurer.
(5) "Commercially domiciled insurer" means and includes any foreign or alien insurer which, during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been licensed to transact its business in this state only for the lesser period of time, has written an average of 25 percent or more direct premiums in this state than it has written in its state of domicile during the same period, or the direct premiums written in this state constitute more than 55 percent of its total direct premiums written everywhere in the United States during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been authorized to transact its business in this state only for the lesser period of time, as reported in its most recent applicable annual or quarterly statements.

624.81 Notice to comply with written requirements of office; noncompliance.—
(1) If the office determines that the conditions set forth in subsection (2) exist, the office shall issue an order placing the insurer in administrative supervision, setting forth the reasons giving rise to the determination, and specifying that the office is applying and effectuating the provisions of this part. An order issued by the office pursuant to this subsection entitles the insurer to request a proceeding under ss. 120.569 and 120.57, and such a request shall stay the action pending such proceeding.
(2) An insurer shall be subject to administrative supervision by the office if upon examination or at any other time the office determines that:
(a) The insurer is in unsound condition;
(b) The insurer's methods or practices render the continuance of its business hazardous to the public or to its insureds; or
(c) The insurer has exceeded its powers granted under its certificate of authority and applicable law.
(3) Within 15 days of receipt of notice of the office's determination to proceed under this part, an insurer shall submit to the office a plan to correct the conditions set forth in the notice. For good cause shown, the office may extend the 15-day time period for submission of the plan. If the office and the insurer agree on a corrective plan, a written agreement shall be entered into to carry out the plan.
(4) If an insurer fails to timely submit a plan, the office may specify the requirements of a plan to address the conditions giving rise to imposition of administrative supervision under this part. In addition, failure of the insurer to timely submit a plan is a violation of the provisions of this code punishable in accordance with s. 624.418.
(5) The plan shall address, but shall not be limited to, each of the activities of the insurer's business which are set forth in s. 624.83.
(6) Any insurer subject to administrative supervision is expected to avail itself of all reasonably available reinsurance. Reasonably available reinsurance shall include unrealized reinsurance, which is defined as reinsurance recoverable on known losses incurred and due under valid reinsurance contracts that have not been identified in the normal course of business and have not been reported in financial statements filed with the Office of

Insurance Regulation. Within 90 days of being placed under administrative supervision, the insurer shall certify to the Director of the Office of Insurance Regulation that the insurer has engaged an independent third party to search for unrealized reinsurance, and that the insurer has made all relevant books and records available to the third party. The compensation to the third party may be a percentage of unrealized reinsurance identified and collected.

(7) If the office and the insurer are unable to agree on the provisions of the plan, the office may require the insurer to take such corrective action as may be reasonably necessary to remove the causes and conditions giving rise to the need for administrative supervision.

(8) The insurer shall have 60 days, or a longer period of time as designated by the office but not to exceed 120 days, after the date of the written agreement or the receipt of the office's plan within which to comply with the requirements of the office. At the conclusion of the initial period of supervision, the office may extend the supervision in increments of 60 days or longer, not to exceed 120 days, if conditions justifying supervision exist. Each extension of supervision shall provide the insurer with a point of entry pursuant to chapter 120.

(9) The initiation or pendency of administrative proceedings arising from actions taken under this section shall not preclude the office from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation or initiating other delinquency proceedings however designated under the laws of this state.

(10) If it is determined that the conditions giving rise to administrative supervision have been remedied so that the continuance of its business is no longer hazardous to the public or to its insureds, the office shall release the insurer from supervision.

(11) The commission may adopt rules to define standards of hazardous financial condition and corrective action substantially similar to that indicated in the National Association of Insurance Commissioners' 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition," which are necessary to implement the provisions of this part.

625.012 "Assets" defined.—In any determination of the financial condition of an insurer, there shall be allowed as "assets" only such assets as are owned by the insurer and which consist of:

(1) Cash or cash equivalents, in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent bank, savings and loan association, or trust company. Cash equivalents are short-term, highly liquid investments, with original maturities of 3 months or less, which are both readily convertible to known amounts of cash and so near their maturity that they present insignificant risk of changes in value because of changes in interest rates.

(2) Investments, securities, properties, and loans acquired or held in accordance with this code, 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 such amount has otherwise been allowed as an asset.

(c) Interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest thereon.

(d) Interest due or accrued on deposits in solvent banks, savings and loan associations, and trust companies, and interest due or accrued on other assets, if such interest is in the judgment of the office a collectible asset.

(e) Interest due or accrued on a current mortgage loan, 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, and rent more than 3 months in arrears if the payment of such rent is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral.
(g) The unaccrued portion of taxes paid prior to the due date on real property.
(3) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy.
(4) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer.
(5)(a) Premiums in the course of collection, other than for life insurance, not more than 3 months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States Government or by any of its instrumentalities. All premiums, excluding commissions payable thereon, due from a controlling or controlled person shall not be allowed as an asset to the extent that:
1. The premiums collected by the controlling or controlled person and not remitted to the insurer are not held in a trust account with a bank or other depository approved by the office. Such funds shall be held as trust funds and may not be commingled with any other funds of the controlling or controlled person. Disbursements from the trust account may be made only to the insurer, the insured, or, for the purpose of returning premiums, an entity who is entitled to returned premiums on behalf of the insured. A written copy of the trust agreement must be filed with and approved by the office prior to its becoming effective. However, the investment income derived from the trust may be allocated as the parties deem proper. A controlling or controlled person shall deposit premiums collected into the trust account within 15 working days after collection;
2. The controlling or controlled person has not provided to the insurer and the insurer has not maintained in its possession an unexpired, clean irrevocable letter of credit, payable to the insurer, issued for a term of not less than 1 year and in conformity with the requirements set forth in this subparagraph, the amount of which equals or exceeds the liability of the controlling or controlled person to the insurer, at all times during the period which the letter of credit is in effect, for premiums collected by the controlling or controlled person. The requirements are that such letter of credit be issued under arrangements satisfactory to the office and that the letter be issued by a banking institution which is a member of the Federal Reserve System and which has a financial standing satisfactory to the office;
3. The controlling or controlled person has not provided to the insurer and the insurer maintained in its possession evidence that the controlling or controlled person has purchased and has currently in effect a financial guaranty bond, payable to the insurer, issued for a term of not less than 1 year and which is in conformity with the requirements set forth in this subparagraph, the amount of which equals or exceeds the liability of the controlling or controlled person to the insurer, at all times during which the financial guaranty bond is in effect, for the premiums collected by the controlling or controlled person. The requirements are that such a financial guaranty bond shall be issued under an arrangement satisfactory to the office and that the financial guaranty bond be issued by an insurer authorized to transact such business in Florida and which has a financial standing satisfactory to the office and which is neither controlled nor controlling in relation to either the insurer or the person for whom the bond is purchased; or
4. A financial evaluation indicates that the controlling or controlled person is unlikely to have the ability to pay such premiums as they become due. The financial evaluation shall be based on a review of the books and records of the controlling or controlled person.

(b) For the purpose of this subsection:
1. "Controlling person" means any person owning, directly or indirectly, 25 percent or more of the voting securities of the insurer.
2. "Controlled person" means any person that is, directly or indirectly, owned or controlled by a controlling person.
3. "Controlling" or "controlled person" means any person that individually or in combination with other such persons owes to the insurer an amount that exceeds 50 percent of the insurer's total premiums in course of collection as stated on the insurer's financial statement.
(c) The office shall disapprove any trust agreement filed pursuant to paragraph (a) which does not assure the safety of the premiums collected.
(6) Installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which such premiums apply.
(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon.
(8) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under s. 624.610.
(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty.
(10) Deposits or equities recoverable from underwriting associations, syndicates, and reinsurance funds, or from any suspended banking institution, to the extent deemed by the office available for the payment of losses and claims and at values to be determined by it.
(11) Electronic and mechanical machines, including computer-operating software equipment and system software constituting a data processing and accounting system, the cost of which is at least $25,000, which cost shall be amortized in full over a period not to exceed 3 calendar years. The aggregate amount admitted under this subsection shall be limited to 3 percent of the insurer's capital and surplus, adjusted to exclude any electronic data processing equipment and operating software, net deferred tax assets, and net positive goodwill, as reported on the insurer's most recently filed annual statement.
(12) Goodwill arising from acquisitions and mergers occurring after January 1, 2001.
(13) Loans or advances by an insurer to its parent or principal owner if approved by the office.
(14) Current income tax recoverables.
(15)(a) Assessments levied pursuant to s. 631.57(3)(a) and (e) that are paid before policy surcharges are collected and result in a receivable for policy surcharges to be collected in the future. This amount, to the extent it is likely that it will be realized, meets the definition of an admissible asset as specified in the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4. The asset shall be established and recorded separately from the liability regardless of whether it is based on a retrospective or prospective premium-based assessment. If an insurer is unable to fully recoup the amount of the assessment because of a reduction in writings or withdrawal from the market, the amount recorded as an asset shall be reduced to the amount reasonably expected to be recouped.
(b) Assessments levied as monthly installments pursuant to s. 631.57(3)(e)3. that are paid after policy surcharges are collected so that the recognition of assets is based on actual premium written offset by the obligation to the Florida Insurance Guaranty Association.
(16) Capitalized interest.
(17) Other assets, not inconsistent with the provisions of this section, deemed by the office to be available for the payment of losses and claims, at values to be determined by it.

625.172 Replacing certain assets; reporting certain liabilities.—

(1) The office, upon determining that an insurer's asset has not been evaluated according to applicable law or that it does not qualify as an asset, shall require the insurer to properly reevaluate the asset or replace the asset with an asset suitable to the office.
(2) The office, upon determining that an insurer has failed to report certain liabilities that should have been reported, shall require that the insurer report such liabilities to the office within 90 days.
(3) If it is determined that the proper valuation of an asset or the establishment of certain liabilities would place the insurer in financial impairment or insolvency, the office may, at its discretion, immediately suspend the certificate of authority of an insurer or take other action it deems appropriate to protect the interests of policyholders or the general public.

625.302 Eligible investments.—
(1) Insurers shall invest in or lend their funds on the security of, and shall hold as invested assets, only eligible investments as prescribed in this part of this chapter.
(2) Any particular investment held by an insurer on the effective date of this code, and which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to such effective date, shall be deemed to be an eligible investment.
(3) Eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in subsection (2).
(4) Any investment limitation based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of December 31 next preceding date of acquisition of the investment by the insurer, or as shown by a current financial statement of the insurer.

625.330 Special investments by title insurer.—
(1) In addition to other investments eligible under this part, a title insurer may invest and have invested an amount not exceeding the greater of $300,000 or 50 percent of that part of its surplus as to policyholders which exceeds the minimum surplus required by s. 624.408 in its abstract plant and equipment, in loans secured by mortgages on abstract plants and equipment, and, with the consent of the office, in stocks of abstract companies. If the insurer transacts kinds of insurance in addition to title insurance, for the purposes of this section its paid-in capital stock shall be prorated between title insurance and such other insurances upon the basis of the reserves maintained by the insurer for the various kinds of insurance; but the capital so assigned to title insurance shall in no event be less than $100,000.
(2) Subsection (1) does not apply to a business trust insurer. Such an insurer may invest and have invested not exceeding the greater of $300,000 or 50 percent of its net trust fund in excess of the reserve provided for under s. 625.111 in abstract plants, stock in abstract companies, or corporations controlled by the business trust and created for developing and servicing abstract plants.
(3) Investments authorized by this section shall not be credited against the insurer's required unearned premium or guaranty fund reserve provided for under s. 625.111.

625.332 Prohibited investments and investment underwriting.—
(1) In addition to investments excluded pursuant to other provisions of this code, an insurer shall not directly or indirectly invest in or lend its funds upon the security of:
(a) Issued shares of its own capital stock, except for the purpose of mutualization under s. 628.431, or in connection with a plan approved by the office for purchase of such shares by the insurer's officers, employees, or agents. No such stock shall, however, constitute an asset of the insurer in any determination of its financial condition.

(b) Except with the consent of the office, securities issued by any corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, or controlling stockholders. Investments in subsidiaries under s. 625.325 shall not be subject to this provision.
(c) Any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the insurer, except as to policy loans authorized under s. 625.321.
(2) No insurer shall underwrite or participate in the underwriting of an offering of securities or property by any other person.

625.338 Time limit for disposal of ineligible property and securities; effect of failure to dispose.—
(1) Any property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at the time of such acquisition shall be disposed of within 3 years from the date of acquisition, unless within such period the security has attained to the standard of eligibility except that any security or property acquired under any agreement of bulk reinsurance, merger, or consolidation may be retained for a longer period if so provided in the plan for such reinsurance, merger, or consolidation as approved by the office under chapter 628. Upon application by the insurer and proof that forced sale of any such property or security would materially injure the interests of the insurer, the office may extend the disposal period for an additional reasonable time.
(2) Any property or securities lawfully acquired and held by an insurer after expiration of the period for disposal thereof or any extension of such period granted by the office shall not be allowed as an asset of the insurer.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.4085 Risk-based capital requirements for insurers.—
(1) As used in this section, the term:
(a) "Adjusted risk-based capital report" means a risk-based capital report that has been adjusted by the office in accordance with this section.
(b) "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in the risk-based capital instructions.
(c) "Company action level risk-based capital" means the product of 2.0 and an insurer's authorized control level risk-based capital.
(d) "Corrective order" means an order issued by the office specifying corrective actions that the office has determined are required.
(e) "Domestic insurer" means any insurer domiciled in this state.
(f) "Foreign insurer" means any insurer that is authorized or eligible to do business in this state but that is not domiciled in this state.
(g) "Life and health insurer" means an insurer authorized or eligible under the Florida Insurance Code to underwrite life or health insurance. The term includes a property and casualty insurer that writes accident and health insurance only. Effective January 1, 2015, the term also includes a health maintenance organization that is authorized in this state and one or more other states, jurisdictions, or countries and a prepaid limited health service organization that is authorized in this state and one or more other states, jurisdictions, or countries.
(h) "Mandatory control level risk-based capital" means the product of 0.70 and the authorized control level risk-based capital.
(i) "Negative trend" means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the risk-based capital instructions.
(j) "Property and casualty insurer" means any insurer licensed under the Florida Insurance Code, but does not include a single-line mortgage guaranty insurer, financial guaranty insurer, or title insurer or a life and health insurer.
(k) "Regulatory action level risk-based capital" means the product of 1.5 and an insurer's authorized control level risk-based capital.
(l) "Revised risk-based capital plan" means the revision of the risk-based capital plan which is prepared by an insurer after the office rejects the original plan.
(m) "Risk-based capital instructions" means the instructions for preparing a risk-based capital report as adopted by the National Association of Insurance Commissioners.
(n) "Risk-based capital level" means an insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital.
(o) "Risk-based capital plan" means a comprehensive financial plan specified in paragraph (4)(b).
(p) "Risk-based capital report" means the report required in subsection (2).
(q) "Total adjusted capital" means the sum of:
1. An insurer's statutory capital and surplus; and
2. Any other item required by the risk-based capital instructions.
(2)(a) Each domestic insurer that is subject to this section shall, on or before March 1 of each year, prepare and file with the National Association of Insurance Commissioners a

report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing the information required in the risk-based capital instructions. In addition, each domestic insurer shall file a printed copy of its risk-based capital report:
1. With the office on or before March 1 of each year.
2. With the insurance department in any other state in which the insurer is authorized to do business, if that department has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:
a. Fifteen days after the receipt of notice to file its risk-based capital report with that state; or
b. March 1.
(b) The comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and may not be used as a means to rank insurers generally. Therefore, except as otherwise required under this section, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; however, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk-based capital levels (or any of them) or an inappropriate comparison of any other amount to the insurer's risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the office with substantial proof the falsity or inappropriateness of the statement, the insurer may publish in a written publication an announcement the sole purpose of which is to rebut the materially false statement.
(c) The office shall use the risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans solely for monitoring the solvency of insurers and assessing the need for corrective action with respect to insurers. The office may not use that information for ratemaking, as evidence in any rate proceeding, or for calculating or deriving any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or an affiliate of such insurer is authorized to write.
(d) A life and health insurer's risk-based capital is determined in accordance with the formula set forth in the risk-based capital instructions. The formula takes into account and may adjust for the covariance between:
1. The risk with respect to the insurer's assets;
2. The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;
3. The interest rate risk with respect to the insurer's business; and
4. Any other business or other relevant risk set out in the risk-based capital instructions,

determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(e) A property and casualty insurer's risk-based capital is determined in accordance with the formula set forth in the risk-based capital instructions. The formula takes into account and may adjust for the covariance between:
1. The asset risk;
2. The credit risk;

3. The underwriting risk; and
4. Any other business or other relevant risk set out in the risk-based capital instructions,

determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(f) The Legislature finds that an excess of capital over the amount produced by the risk-based capital requirements and the formulas, schedules, and instructions specified in this section is a desirable goal with respect to the business of insurance. Accordingly, insurers should seek to maintain capital above the risk-based capital levels required by this section. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this section.

(g) If a domestic insurer files a risk-based capital report that the office finds is inaccurate, the office shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must state the reason for the adjustment. A risk-based capital report that is so adjusted is referred to as the adjusted risk-based capital report. The adjusted risk-based capital report must also be filed by the insurer with the National Association of Insurance Commissioners.

(3)(a) A company action level event includes:

1. The filing of a risk-based capital report by an insurer which indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital;

b. If a life and health insurer reports using the life and health annual statement instructions, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital, but is less than the product of its authorized control level risk-based capital and 3.0, and has a negative trend;

c. Effective January 1, 2015, if a life and health or property and casualty insurer reports using the health annual statement instructions, the insurer or organization has total adjusted capital that is greater than or equal to its company action level risk-based capital, but is less than the product of its authorized control level risk-based capital and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Risk-Based Capital Forecasting and Instructions, Health, updated annually by the NAIC; or

d. If a property and casualty insurer reports using the property and casualty annual statement instructions, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital, but less than the product of its authorized control level risk-based capital and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Risk-Based Capital Forecasting and Instructions, Property/Casualty, updated annually by the NAIC;

2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates an event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7); or

3. If, under subsection (7), an insurer challenges an adjusted risk-based capital report that indicates an event in subparagraph 1., the notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge.

(b) If a company action level event occurs, the insurer shall prepare and submit to the office a risk-based capital plan, which must:

1. Identify the conditions that contribute to the company action level event;

2. Contain proposals of corrective actions that the insurer intends to take and that are reasonably expected to result in the elimination of the company action level event;

3. Provide projections of the insurer's financial results in the current year and at least the 4 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and, if separate projections are provided, must separately identify each significant income, expense, and benefit component;
4. Identify the key assumptions affecting the insurer's projections and the sensitivity of the projections to the assumptions; and
5. Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and any use of reinsurance.
(c) The risk-based capital plan must be submitted:
1. Within 45 days after the company action level event; or
2. If the insurer challenges an adjusted risk-based capital report under subsection (7), within 45 days after notification to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(d) Within 60 days after the submission by an insurer of a risk-based capital plan to the office, the office shall notify the insurer whether the risk-based capital plan must be implemented or is, in the judgment of the office, unsatisfactory. If the office determines that the risk-based capital plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may set forth proposed revisions. Upon notification from the office, the insurer shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the office, and shall submit the revised risk-based capital plan to the office:
1. Within 45 days after the notification from the office; or
2. If the insurer challenges the notification from the office under subsection (7), within 45 days after a notification to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(e) If the office notifies an insurer that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the office may, at its discretion and subject to the insurer's right to a hearing under subsection (7), specify in the notification that the notification is a regulatory action level event.
(f) Each domestic insurer that files a risk-based capital plan or a revised risk-based capital plan with the office shall file a copy of the risk-based capital plan or the revised risk-based capital plan with the insurance department in any other state in which the insurer is authorized to do business if:
1. That state has a risk-based capital law that is substantially similar to paragraph (8)(a); and
2. The insurance department of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk-based capital plan or the revised risk-based capital plan in that state no later than the later of:
a. Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or
b. The date on which the risk-based capital plan or the revised risk-based capital plan is filed under paragraph (c) or paragraph (d).
(4)(a) A regulatory action level event includes:
1. The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk-based capital but is less than its regulatory action level risk-based capital;
2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates the event described in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7);

3. If, under subsection (7), the insurer challenges an adjusted risk-based capital report that indicates the event described in subparagraph 1., the notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge;
4. The failure of the insurer to file a risk-based capital report by the filing date, unless the insurer provides an explanation for such failure which is satisfactory to the office and cures the failure within 10 days after the filing date;
5. The failure of the insurer to submit a risk-based capital plan to the office within the time period set forth in paragraph (3)(c);
6. Notification by the office to the insurer that:
a. The risk-based capital plan or the revised risk-based capital plan submitted by the insurer is, in the judgment of the office, unsatisfactory; and
b. This notification constitutes a regulatory action level event with respect to the insurer, unless the insurer challenges the determination under subsection (7);
7. If, under subsection (7), the insurer challenges a determination by the office under subparagraph 6., the notification by the office to the insurer that the office has, after a hearing, rejected the challenge;
8. Notification by the office to the insurer that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if this failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the office has so stated in the notification, unless the insurer challenges the determination under subsection (7); or
9. If, under subsection (7), the insurer challenges a determination by the office under subparagraph 8., the notification by the office to the insurer that the office has, after a hearing, rejected the challenge.
(b) If a regulatory action level event occurs, the office shall:
1. Require the insurer to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;
2. Perform an examination pursuant to s. 624.316 or an analysis, as the office considers necessary, of the assets, liabilities, and operations of the insurer, including a review of the risk-based capital plan or the revised risk-based capital plan; and
3. After the examination or analysis, issue a corrective order specifying such corrective actions as the office determines are required.
(c) In determining corrective actions, the office shall consider any factor relevant to the insurer based upon the office's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken as provided in the risk-based capital instructions. The risk-based capital plan or the revised risk-based capital plan must be submitted:
1. Within 45 days after the occurrence of the regulatory action level event;
2. If the insurer challenges an adjusted risk-based capital report under subsection (7), within 45 days after the notification to the insurer that the office has, after a hearing, rejected the insurer's challenge; or
3. If the insurer challenges a revised risk-based capital plan under subsection (7), within 45 days after the notification to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(d) The office may retain actuaries, investment experts, and other consultants to review an insurer's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations of an insurer, and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or by any other party as directed by the office.
(5)(a) An authorized control level event includes:

1. The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but is less than its authorized control level risk-based capital;
2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates the event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7);
3. If, under subsection (7), the insurer challenges an adjusted risk-based capital report that indicates the event in subparagraph 1., notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge;
4. The failure of the insurer to respond, in a manner satisfactory to the office, to a corrective order, unless the insurer challenges the corrective order under subsection (7); or
5. If the insurer challenges a corrective order under subsection (7) and the office has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the office, to the corrective order after rejection or modification by the office.
(b) If an authorized control level event occurs, the office shall:
1. Take any action required under subsection (4) regarding the insurer with respect to which a regulatory action level event has occurred; or
2. If the office considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take any action as necessary to cause the insurer to be placed under regulatory control under chapter 631. An authorized control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631.
(6)(a) A mandatory control level event includes:
1. The filing of a risk-based capital report that indicates that the insurer's total adjusted capital is less than its mandatory control level risk-based capital;
2. Notification by the office to the insurer of an adjusted risk-based capital report that indicates the event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7); or
3. If, under subsection (7), the insurer challenges an adjusted risk-based capital report that indicates the event in subparagraph 1., notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(b) If a mandatory control level event occurs:
1. With respect to a life and health insurer, the office shall, after due consideration of s. 624.408, and effective January 1, 2015, ss. 636.045 and 641.225, take any action necessary to place the insurer under regulatory control, including any remedy available under chapter 631. A mandatory control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631. The office may forego taking action for up to 90 days after the mandatory control level event if the office finds there is a reasonable expectation that the event may be eliminated within the 90-day period.
2. With respect to a property and casualty insurer, the office shall, after due consideration of s. 624.408, take any action necessary to place the insurer under regulatory control, including any remedy available under chapter 631, or, in the case of an insurer that is not writing new business, may allow the insurer to continue to operate under the supervision of the office. In either case, the mandatory control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631. The office may forego taking action for up to 90 days after the mandatory control level event if the office finds there is a reasonable expectation that the event may be eliminated within the 90-day period.
(7)(a) An insurer has a right to a hearing before the office upon:
1. Notification to an insurer by the office of an adjusted risk-based capital report;
2. Notification to an insurer by the office that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, and that the notification constitutes a regulatory action level event with respect to such insurer;

3. Notification to any insurer by the office that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its risk-based capital plan or its revised risk-based capital plan; or
4. Notification to an insurer by the office of a corrective order with respect to the insurer.
(b) At such hearing the insurer may challenge any determination or action by the office. The insurer shall notify the office of its request for a hearing within 5 days after receipt of the notification by the office under this subsection. Upon receipt of the request for a hearing, the office shall set a date for the hearing, which date must be no fewer than 10 nor more than 30 days after the date the office receives the insurer's request. The hearing must be conducted as provided in s. 624.324, with the right to appellate review under s. 120.68.
(8)(a) Any foreign insurer shall, upon the written request of the office, submit to the office a risk-based capital report, as of the end of the calendar year just ended, no later than the later of:
1. The date a risk-based capital report is required to be filed by a domestic insurer under this section; or
2. Fifteen days after the request is received by the foreign insurer.
(b) Any foreign insurer shall, upon the written request of the office, promptly submit to the office a copy of any risk-based capital plan that is filed with the insurance department of another state.
(c) The office may require a foreign insurer to file a risk-based capital plan if:
1. A company action level event, regulatory action level event, or authorized control level event occurs with respect to any foreign insurer as determined under the risk-based capital law of the state of domicile of the insurer, or, if there is no risk-based capital law in that state, under this section.
2. The insurance department of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under the risk-based capital law of that state, or, if there is no risk-based capital law in that state, under subsection (3).

The failure of the foreign insurer to file a risk-based capital plan with the office when required under this paragraph is a ground for the office to take any action under s. 624.418 which it determines is necessary.

(d) If a mandatory control level event occurs with respect to any foreign insurer and a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation law of the state of domicile of the foreign insurer, the office may apply to the Circuit Court of Leon County and such event constitutes grounds for the department to be appointed as receiver as provided in chapter 631 with respect to the liquidation of property of foreign insurers found in this state. The occurrence of a mandatory control level event is a ground for such application.
(9) There shall be no liability on the part of, and no cause of action shall arise against, the commission, department, or office, or their employees or agents, for any action taken by them in the performance of their powers and duties under this section.
(10) The office shall transmit any notice that may result in regulatory action by registered mail, certified mail, or any other method of transmission. Notice is effective when the insurer receives it.
(11) This section is supplemental to the other laws of this state and does not preclude or limit any power or duty of the department or office under those laws or under the rules adopted under those laws.
(12) This section does not apply to a domestic property and casualty insurer that meets all of the following conditions:
(a) Writes direct business only in this state;

(b) Writes direct annual premiums of $2 million or less; and
(c) Assumes no reinsurance in excess of 5 percent of direct premiums written.
(13) The commission may adopt rules to administer this section, including, but not limited to, those regarding risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, corrective orders and procedures to be followed in the event of a triggering of a company action level event, a regulatory action level event, an authorized control level event, or a mandatory control level event.

624.4243 Reporting of premium growth.—
(1) Each insurer that has been authorized to transact property and casualty insurance in this state for a continuous period of less than 3 years shall monthly calculate its premium growth as follows:
(a) For the 12-month period ending on the last day of the previous month, obtain the amount of the insurer's direct and assumed written premiums for the United States and its territories.
(b) For the 12-month period immediately preceding the 12-month period specified in paragraph (a), obtain the amount of the insurer's direct and assumed written premiums for the United States and its territories.
(c) Subtract the amount of premiums calculated under paragraph (b) from the amount of premiums calculated under paragraph (a).
(d) Divide the amount of premiums determined under paragraph (c) by the amount of premiums determined under paragraph (b).
(2) Until an insurer has held a certificate of authority in this state for 24 months, the insurer shall, instead of making the calculations required under subsection (1), report to the office no later than the last day of each month the insurer's direct and assumed written premiums from the United States and its territories for the previous month.
(3) If the amount of the premium growth calculated by an insurer under this section exceeds 33 percent, the insurer shall, within 30 days after the end of the 12-month period ending on the last day of the previous month, file with the office a statement of the premium growth calculations under this section. The commission shall adopt rules specifying the form for the report. In response to a report under this section, the office may require the insurer to submit an explanation of the insurer's pattern of premium growth.
(4) For the purposes of this section, direct and assumed written premiums shall be calculated in the same manner as for the preparation of the insurer's annual statement under s. 624.424.

624.424 Annual statement and other information.—

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or

reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office. (10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

624.307 General powers; duties.—

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.324 Hearings.—The department, commission, and office may each hold hearings for any purpose within the scope of this code deemed to be necessary.

624.610 Reinsurance.—

(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:

1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.

(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.

(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.

(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.316 Examination of insurers.—
(1)(a) The office shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer and of the attorney in fact of a reciprocal insurer as to its transactions affecting the insurer as often as it deems advisable, except as provided in this section. The examination may include examination of the affairs, transactions, accounts, and records relating directly or indirectly to the insurer and of the assets of the insurer's managing general agents and controlling or controlled person, as defined in s. 625.012. The examination shall be pursuant to a written order of the office. Such order shall expire upon receipt by the office of the written report of the examination.
(b) As a part of its examination procedure, the office shall examine each insurer regarding all of the information required by s. 627.915.
(c) The office shall examine each insurer according to accounting procedures designed to fulfill the requirements of generally accepted insurance accounting principles and practices and good internal control and in keeping with generally accepted accounting forms, accounts, records, methods, and practices relating to insurers. To facilitate uniformity in examinations, the commission may adopt, by rule, the Market Conduct Examiners Handbook and the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners, 2002, and may adopt subsequent amendments thereto, if the examination methodology remains substantially consistent.
(2)(a) Except as provided in paragraph (f), the office may examine each insurer as often as may be warranted for the protection of the policyholders and in the public interest, and shall examine each domestic insurer not less frequently than once every 5 years. The examination shall cover the preceding 5 fiscal years of the insurer and shall be commenced within 12 months after the end of the most recent fiscal year being covered by the examination. The examination may cover any period of the insurer's operations since the last previous examination. The examination may include examination of events subsequent to the end of the most recent fiscal year and the events of any prior period that affect the present financial condition of the insurer.
(b) The office shall examine each insurer applying for an initial certificate of authority to transact insurance in this state before granting the initial certificate.
(c) In lieu of making its own examination, the office may accept a full report of the last recent examination of a foreign insurer, certified to by the insurance supervisory official of another state.
(d) The examination by the office of an alien insurer shall be limited to the alien insurer's insurance transactions and affairs in the United States, except as otherwise required by the office.
(e) The commission shall adopt rules providing that an examination under this section may be conducted by independent certified public accountants, actuaries, investment specialists, information technology specialists, and reinsurance specialists meeting criteria specified by rule. The rules shall provide:

1. That the rates charged to the insurer being examined are consistent with rates charged by other firms in a similar profession and are comparable with the rates charged for comparable examinations.
2. That the firm selected by the office to perform the examination has no conflicts of interest that might affect its ability to independently perform its responsibilities on the examination.
3. That the insurer being examined must make payment for the examination pursuant to s. 624.320(1) in accordance with the rates and terms established by the office and the firm performing the examination.
(f) An examination under this section must be conducted at least once every year with respect to a domestic insurer that has continuously held a certificate of authority for less than 3 years. The examination must cover the preceding fiscal year or the period since the last examination of the insurer. The office may limit the scope of the examination.

625.121 Standard Valuation Law; life insurance.—

(3) ACTUARIAL OPINION OF RESERVES.—
(a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commission by rule shall define the specifics of this opinion and add any other items determined necessary to its scope.
1. The opinion shall be submitted with the annual statement and must reflect the valuation of such reserve liabilities for each year ending on or before December 31 of the year before the operative date of the valuation manual as defined in s. 625.1212(2), and in accordance with s. 625.1212(4) for each year thereafter.
2. The opinion applies to all business in force, including individual and group health insurance plans, in the form and substance acceptable to the office as specified by rule of the commission.
3. The commission may adopt rules providing the standards of the actuarial opinion consistent with standards adopted by the Actuarial Standards Board on December 31, 2013, and subsequent revisions thereto if the standards remain substantially consistent.
4. The office may accept an opinion filed by a foreign or alien insurer with the insurance supervisory official of another state if the office determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state.
5. As used in this subsection, the term "qualified actuary" means a member in good standing of the American Academy of Actuaries who also meets the requirements specified by rule of the commission.
6. Disciplinary action by the office against the insurer or the qualified actuary shall be in accordance with the insurance code and related rules adopted by the commission.
7. A memorandum in the form and substance specified by rule shall be prepared to support each actuarial opinion.
8. If the insurer fails to provide a supporting memorandum at the request of the office within a period specified by rule of the commission, or if the office determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by rule of the commission, the office may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare such supporting memorandum as required by the office.
9. Except as otherwise provided in this subparagraph, any memorandum or other material in support of the opinion is confidential and exempt from s. 119.07(1) and is not subject to

subpoena or discovery directly from the office; however, the memorandum or other material may be released by the office with the written consent of the insurer, or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the office for preserving the confidentiality of the memorandum or other material. If any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, no portion of the memorandum is confidential. Neither the office nor any person who receives documents, materials, or other information while acting under the authority of the office or with whom such information is shared pursuant to this paragraph may testify in a private civil action concerning the confidential documents, materials, or information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. A waiver of an applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the office under this section or any other section of the insurance code, or as a result of sharing as authorized under s. 624.4212.
(b) In addition to the opinion required by paragraph (a), the office may, pursuant to commission rule, require an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including, but not limited to, the benefits under, and expenses associated with, the policies and contracts.
(c) The commission may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.3161 Market conduct examinations.—
(1) As often as it deems necessary, the office shall examine each licensed rating organization, each advisory organization, each group, association, carrier, as defined in s. 440.02, or other organization of insurers which engages in joint underwriting or joint reinsurance, and each authorized insurer transacting in this state any class of insurance to which the provisions of chapter 627 are applicable. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of chapters 440, 624, 626, 627, and 635.
(2) In lieu of any such examination, the office may accept the report of a similar examination made by the insurance supervisory official of another state.
(3) The examination may be conducted by an independent professional examiner under contract to the office, in which case payment shall be made directly to the contracted examiner by the insurer examined in accordance with the rates and terms agreed to by the office and the examiner.
(4) The reasonable cost of the examination shall be paid by the person examined, and such person shall be subject, as though an insurer, to the provisions of s. 624.320.

(5) Such examinations shall also be subject to the applicable provisions of chapter 440 and ss. 624.318, 624.319, 624.321, and 624.322.
(6) Based on the findings of a market conduct examination that an insurer has exhibited a pattern or practice of willful violations of an unfair insurance trade practice related to claims-handling which caused harm to policyholders, as prohibited by s. 626.9541(1)(i), the office may order an insurer pursuant to chapter 120 to file its claims-handling practices and procedures related to that line of insurance with the office for review and inspection, to be held by the office for the following 36-month period. Such claims-handling practices and procedures are public records and are not trade secrets or otherwise exempt from the provisions of s. 119.07(1). As used in this section, "claims-handling practices and procedures" are any policies, guidelines, rules, protocols, standard operating procedures, instructions, or directives that govern or guide how and the manner in which an insured's claims for benefits under any policy will be processed.

624.320 Examination expenses.—
(1) Each insurer so examined shall pay to the office the expenses of the examination at the rates adopted by the office. Such expenses shall include actual travel expenses, reasonable living expense allowance, compensation of the examiner or other person making the examination, and necessary attendant administrative costs of the office directly related to the examination. Such travel expense and living expense allowance shall be limited to those expenses necessarily incurred on account of the examination and shall be paid by the examined insurer together with compensation upon presentation by the office to such insurer of a detailed account of such charges and expenses after a detailed statement has been filed by the examiner and approved by the office.
(2) All moneys collected from insurers for examinations shall be deposited into the Insurance Regulatory Trust Fund, and the office may make deposits from time to time into such fund from moneys appropriated for the operation of the office.
(3) Notwithstanding the provisions of s. 112.061, the office may pay to the examiner or person making the examination out of such trust fund the actual travel expenses, reasonable living expense allowance, and compensation in accordance with the statement filed with the office by the examiner or other person, as provided in subsection (1) upon approval by the office.
(4) When not examining an insurer, the travel expenses, per diem, and compensation for the examiners and other persons employed to make examinations, if approved, shall be paid out of moneys budgeted for such purpose as regular employees, reimbursements for such travel expenses and per diem to be at rates no more than as provided in s. 112.061.
(5) The office may pay to regular insurance examiners, not residents of Leon County, Florida, per diem for periods not exceeding 30 days for each such examiner while at the Office of Insurance Regulation in Tallahassee, Florida, for the purpose of auditing insurers' annual statements. Such expenses shall be paid out of moneys budgeted for such purpose, as for regular employees at rates provided in s. 112.061.
(6) The provisions of this section shall apply to rate analysts and rate examiners in the discharge of their duties under s. 624.3161.

624.321 Witnesses and evidence.—
(1) As to any examination, investigation, or hearing being conducted under this code, a person designated by the department or office, respectively:
(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence; and

(b) Shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the production of books, papers, records, files, correspondence, documents, or other evidence which is relevant to the inquiry.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as

its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

625.331 Special consent investments.—
(1) After satisfying the requirements of this part, any funds of an insurer in excess of its reserves and policyholders' surplus required to be maintained may be invested:
(a) Without limitation in any investments otherwise authorized by this part; or
(b) In such other investments not specifically authorized by this part as long as such investments do not exceed the lesser of 5 percent of the insurer's total admitted assets or 25 percent of the amount by which the insurer's policyholders' surplus exceeds the minimum required to be maintained.

The limitations in paragraph (b) may be exceeded if consented to in writing by the office.

(2) In no case shall the investments authorized under this section being held by an insurer be greater than the amount by which the insurer's policyholders' surplus exceeds the minimum required to be maintained.
(3) Notwithstanding the provisions of this section, an insurer may not invest in investments prohibited by this code.

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627.357 Medical malpractice self-insurance.—
(1) DEFINITIONS.—As used in this section, the term:
(a) "Fund" means a group or association of health care providers authorized to self-insure.
(b) "Health care provider" means any:
1. Hospital licensed under chapter 395.
2. Physician licensed, or physician assistant licensed, under chapter 458.
3. Osteopathic physician or physician assistant licensed under chapter 459.
4. Podiatric physician licensed under chapter 461.
5. Health maintenance organization certificated under part I of chapter 641.
6. Ambulatory surgical center licensed under chapter 395.
7. Chiropractic physician licensed under chapter 460.
8. Psychologist licensed under chapter 490.
9. Optometrist licensed under chapter 463.
10. Dentist licensed under chapter 466.
11. Pharmacist licensed under chapter 465.
12. Registered nurse, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464.
13. Other medical facility.
14. Professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9., 10., 11., and 12. for professional activity.
(c) "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment and in which the patient is admitted to and discharged from such facility within the same working day, and which is not part of a hospital. The term does not include a facility existing for the primary purpose of performing terminations of pregnancies or an office maintained by a physician or dentist for the practice of medicine.
(d) "Hospital subsidiary corporation" means any corporation over which a hospital or the hospital's parent corporation exercises financial or operational control and which provides health care services to the hospital or the hospital parent corporation or another hospital subsidiary corporation.
(e) "Hospital parent corporation" means any corporation which has financial or operational control over a hospital and which provides health care services to the hospital or another hospital subsidiary corporation.
(f) "Committee" means a committee or board of trustees of a health care provider or group of health care providers established to make recommendations, policies, or decisions regarding patient institutional utilization, patient treatment, or institutional staff privileges or to perform other administrative or professional purposes or functions.
(2) A group or association of health care providers composed of any number of members, is authorized to self-insure against claims arising out of the rendering of, or failure to render, medical care or services, or against claims for injury or death to the insured's patients arising out of the insured's activities, upon obtaining approval from the office and upon complying with the following conditions:
(a) Establishment of a Medical Malpractice Risk Management Trust Fund to provide coverage against professional medical malpractice liability.
(b) Employment of professional consultants for loss prevention and claims management coordination under a risk management program.

(3) The fund may insure hospital parent corporations, hospital subsidiary corporations, and committees against claims arising out of the rendering of, or failure to render, medical care or services.
(4) The fund is subject to regulation and investigation by the office. The fund is subject to rules of the commission and to part IX of chapter 626, relating to trade practices and frauds.
(5) The trust fund may purchase medical malpractice insurance, specific excess insurance, and aggregate excess insurance, up to determined limits, as necessary to provide the insurance coverages authorized by this section, consistent with market availability. The trust fund may purchase such risk management services as may be required, pay claims as may arise under any deductible provisions, and engage in prudent investment of trust funds and other activities reasonably relating to the payment of claims and to providing medical malpractice self-insurance, to the extent otherwise consistent with this section and law generally applicable to medical malpractice insurers.
(6) The commission shall adopt rules to implement this section, including rules that ensure that a trust fund remains solvent and maintains a sufficient reserve to cover contingent liabilities under subsection (7) in the event of its dissolution.
(7)(a) The liability of each member for the obligations of the trust fund is individual, several, and proportionate, but not joint, except as provided in this subsection.
(b) Each member has a contingent assessment liability for payment of actual losses and expenses incurred while the member's policy was in force.
(c) The trust fund may from time to time assess members of the fund liable therefor under the terms of their policies and pursuant to this section. The office may assess the members in the event of liquidation of the fund.
(d) A member's share of a deficiency for which an assessment is made is computed by applying to the premium earned on the member's policy or policies during the period to be covered by the assessment the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment. If one or more members fail to pay an assessment, the other members are liable on a proportionate basis for an additional assessment. The fund, acting on behalf of all members who paid the additional assessment, shall institute legal action, when necessary and appropriate, to recover the assessment from members who failed to pay it.
(e) In computing the earned premiums for the purposes of this section, the gross premium received by the fund for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.
(f) No member has an offset against any assessment for which the member is liable, on account of any claim for unearned premium of losses payable.
(g) If the assets of a trust fund are at any time insufficient to comply with the requirements of law, discharge the fund's liabilities, or meet the required conditions of financial soundness, or if a judgment against the fund has remained unsatisfied for 30 days, the trust fund must immediately make up the deficiency or levy an assessment upon the members for the amount needed to make up the deficiency, subject to the limitations set forth in this subsection.
(h) If the trust fund fails to make an assessment as required by paragraph (g), the office shall order the fund to do so. If the deficiency is not sufficiently made up within 60 days after the date of the order, the fund is deemed insolvent and grounds exist to proceed against the fund as provided for in part I of chapter 631.
(i) Subject to this section, any rehabilitation, liquidation, conservation, or dissolution of a trust fund shall be conducted under the supervision of the department, which has all power with respect thereto granted to it under part I of chapter 631 governing the rehabilitation, liquidation, conservation, or dissolution of insurers.
(8) The expense factors associated with rates used by a fund shall be filed with the office at least 30 days prior to use and may not be used until approved by the office. The office

shall disapprove the rates unless the filed expense factors associated therewith are justified and reasonable for the benefits and services provided.
(9) Premiums, contributions, and assessments received by a fund are subject to ss. 624.509(1) and (2) and 624.5092, except that the tax rate is 1.6 percent of the gross amount of such premiums, contributions, or assessments.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.424 Annual statement and other information.—

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

627.4147 Medical malpractice insurance contracts.—
(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or s. 624.462 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:
(a) A clause requiring the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice of intent to file a claim for medical malpractice is made against the insured.
(b)1. A clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.
2. If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

(c) A clause requiring the insurer or self-insurer to notify the insured no less than 90 days prior to the effective date of cancellation of the policy or contract and, in the event of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 90 days prior to the end of the policy or contract period. If cancellation or nonrenewal is due to nonpayment or loss of license, 10 days' notice is required.
(d) A clause requiring the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of a rate increase. The provisions of s. 627.4133 shall apply to such notice and to the failure of the insurer to provide such notice to the extent not in conflict with this section.
(2) Each insurer covered by this section may require the insured to be a member in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or local professional society of health care providers which maintains a medical review committee. No professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization licensed under part I of chapter 641.
(3) This section shall apply to all policies issued or renewed after October 1, 2003.

627.4148 Medical malpractice insurers; required offer of coverage limits.—An insurer issuing policies of professional liability coverage for claims arising out of the rendering of, or the failure to render, medical care or services shall make available to physicians licensed under chapter 458 and to osteopathic physicians licensed under chapter 459 coverage with the following limits, subject to usual underwriting standards:
(1) One hundred thousand dollars per claim, $300,000 annual aggregate; and
(2) Two hundred fifty thousand dollars per claim, $750,000 annual aggregate.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

625.091 Losses and loss adjustment expense reserves; liability insurance and workers' compensation insurance.—The reserve liabilities recorded in the insurer's annual statement and financial statements for unpaid losses and loss adjustment expenses shall be the estimated value of its claims when ultimately settled and shall be computed as follows:
(1) For all liability and workers' compensation claims, the statement and statutory reserves and loss adjustment expenses shall be in accordance with the form of the annual statement as required in s. 624.424, and shall include the computed, determined, or estimated value of the unpaid reported claims and loss adjustment expenses, allocated and unallocated, and a provision for loss and loss adjustment expenses, allocated and unallocated, that are incurred but not reported. For claims under liability policies, the reserve for reported claims shall not be less than $1,000 for each outstanding liability suit.
(2)(a) Workers' compensation tabular reserves and long-term disability claims including death claims may be reserved at the present value at 4 percent interest of the determined and the estimated future payments.
(b) If workers' compensation reserves are discounted in accordance with paragraph (a), discounted loss and loss expense reserves shall be used in the computation of excess statutory reserves over statement reserves.
(3) Structured settlements may be used to reduce reserves if:
(a) There is the purchase of an annuity by the insurer to fund future payments that are fixed or determined by settlement provisions or statutes wherein the claimant is the payee, the transaction may be treated as a paid claim and the reserve taken down accordingly. The appropriate disclosure of the contingent liability for such amount must be disclosed in notes to the financial statements of the annual statement; or
(b) The insurer assigns the obligation to make periodic payments to a third party and obtains a full and complete release from the claimant, the claim may be treated as a paid claim without additional disclosure.
(4)(a) Accounting credit for anticipated recoveries from the Special Disability Trust Fund may only be taken in the determination of loss reserves and may not be reflected on the financial statements in any manner other than that allowed pursuant to this subsection.
(b)1. For calendar years 1999-2003, an insurer recording anticipated recoveries from the Special Disability Trust Fund shall limit the aggregate amount to the amount management reasonably expects will be reimbursed or the following amount, whichever is lower:

a. For financial statements filed in 2000, an insurer may take accounting credit in an amount equaling 80 percent of the amount utilized in calendar year 1996.
b. For financial statements filed in 2001, an insurer may take accounting credit in an amount equaling 60 percent of the amount utilized in calendar year 1996.
c. For financial statements filed in 2002, an insurer may take accounting credit in an amount equaling 40 percent of the amount utilized in calendar year 1996.
d. For financial statements filed in 2003, an insurer may take accounting credit in an amount equaling 20 percent of the amount utilized in calendar year 1996.
2. Subparagraph 1. does not apply to an insurer recording anticipated recoveries from the Special Disability Trust Fund on the basis of:
a. A proof of claim which the fund has reviewed, determined to be a valid claim and so notified the carrier, and extended a payment offer; or
b. A reimbursement request audited and approved for payment or paid by the fund;
(c) Beginning with financial statements filed in 2004, an insurer may only take accounting credit for anticipated recoveries from the Special Disability Trust Fund for each proof of claim which the fund has reviewed, determined to be a valid claim and so notified the carrier, and extended a payment offer; or a reimbursement request audited and approved for payment or paid by the fund.
(d)1. Beginning in calendar year 1998, each insurer shall separately identify anticipated recoveries from the Special Disability Trust Fund on the annual statement required to be filed pursuant to s. 624.424.
2. For all financial statements filed with the office, each insurer shall disclose in the notes to the financial statements of any financial statement required to be filed pursuant to s. 624.424 any credit in loss reserves taken for anticipated recoveries from the Special Disability Trust Fund. That disclosure shall include:
a. The amount of credit taken by the insurer in the determination of its loss reserves for the prior calendar year and the current reporting period on a year-to-date basis.
b. The amount of payments received by the insurer from the Special Disability Trust Fund during the prior calendar year and the year-to-date recoveries for the current year.
c. The amount the insurer was assessed by the Special Disability Trust Fund during the prior calendar year and during the current calendar year.

690-167.012

627.701 Liability of insureds; coinsurance; deductibles.—

(6)(a) It is the intent of the Legislature to encourage the use of higher hurricane deductibles as a means of increasing the effective capacity of the hurricane insurance market in this state and as a means of limiting the impact of rapidly changing hurricane insurance premiums. The Legislature finds that the hurricane deductibles specified in this subsection are reasonable when a property owner has made adequate provision for restoration of the property to its full value after a catastrophic loss.
(b) A personal lines residential insurance policy providing hurricane coverage may, at the mutual option of the insured and insurer, include a secured hurricane deductible as described in paragraph (c) if the applicant presents the insurer a certificate of security as described in paragraph (d). An insurer may not directly or indirectly require a secured deductible under this subsection as a condition of issuing or renewing a policy. A certificate of security is not required with respect to an applicant who owns a 100 percent equity interest in the property.
(c) A secured hurricane deductible must include the substance of the following:
1. The first $500 of any claim, regardless of the peril causing the loss, is fully deductible.
2. With respect to hurricane losses only, the next $5,000 in losses are fully insured, subject only to a copayment requirement of 10 percent.
3. With respect to hurricane losses only, the remainder of the claim is subject to a deductible equal to a specified percentage of the policy dwelling limits in excess of the deductible allowed under former paragraph (3)(a) but no higher than 10 percent of the policy dwelling limits.
4. The insurer agrees to renew the coverage on a guaranteed basis for a period of years after initial issuance of the secured deductible equal to at least 1 year for each 2 percentage points of deductible specified in subparagraph 3. unless the policy is canceled for nonpayment of premium or the insured fails to maintain the certificate of security. Such renewal shall be at the same premium as the initial policy except for premium changes attributable to changes in the value of the property.
(d) The office shall draft and formally propose as a rule the form for the certificate of security. The certificate of security may be issued in any of the following circumstances:
1. A mortgage lender or other financial institution may issue a certificate of security after granting the applicant a line of credit, secured by equity in real property or other reasonable security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. In the sole discretion of the mortgage lender or other financial institution, the line of credit may be issued to an applicant on an unsecured basis.
2. A licensed insurance agent may issue a certificate of security after obtaining for an applicant a line of credit, secured by equity in real property or other reasonable security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. The Florida Hurricane Catastrophe Fund shall negotiate agreements creating a financing consortium to serve as an additional source of lines of credit to secure deductibles. Any licensed insurance agent may act as the agent of such consortium.
3. Any person qualified to act as a trustee for any purpose may issue a certificate of security secured by a pledge of assets, with the restriction that the assets may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.
4. Any insurer, including any admitted insurer or any surplus lines insurer, may issue a certificate of security after issuing the applicant a policy of supplemental insurance that will

pay for 100 percent of the deductible portion of insured construction or reconstruction after a hurricane loss.
5. Any other method approved by the office upon finding that such other method provides a similar level of security as the methods specified in this paragraph and that such other method has no negative impact on residential property insurance catastrophic capacity. The legislative intent of this subparagraph is to provide the flexibility needed to achieve the public policy of expanding property insurance capacity while improving the affordability of property insurance.
(e) An issuer of a certificate of security may terminate the certificate for failure to honor any of the terms of the underlying financial arrangement. The issuer must provide notice of termination to the insurer within 10 working days after termination. Unless the policyholder obtains a replacement certificate of security within an additional 20 working days after such notice, the deductible provision in the policy must revert to a lower deductible otherwise offered by the insurer and the policyholder is responsible for any additional premium required for a policy with such deductible.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the

department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to

by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

690-188

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.470 Annual reports.—
(1)(a) Every self-insurance fund shall, annually within 3 months of the end of the fiscal year, file a financial statement of the fund, including its balance sheet and a statement of operations for the preceding year, verified by the oath of a member of the board of trustees or by an administrative executive appointed by the board. An entry for future investment income, reported on or after January 1, 1998, may only be reflected as an aggregate write-in asset on the balance sheet of the annual and quarterly financial statements. Future investment income shall be calculated as the sum of the admitted asset value of Line 1 (Bonds) plus the admitted asset value of Line 6 (Cash and Short-Term Investments) as reported on page 2 in the annual or quarterly financial statement, times the 3-year treasury note yield as of the date of the financial statement, times 3.
(b) For financial statements filed on or after January 1, 1998, future investment income may only be reported as an admitted asset by an Assessable Mutual or Self-Insurance Fund which reported future investment income in financial statements filed with the [1]Department of Insurance prior to January 1, 1998.
(2) Every fund shall, annually within 6 months of the end of the fiscal year, file a report with the office verified by the oath of a member of the board of trustees or by an administrative executive appointed by the board, containing the following information:
(a) A financial statement of the fund, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant.
(b) A report prepared by an actuary who is a member of the American Academy of Actuaries as to the actuarial soundness of the fund. The report shall consist of, but shall not be limited to, the following:
1. Adequacy of premiums or contributions in paying claims and changes, if any, needed in the contribution rates to achieve or preserve a level of funding deemed adequate, which shall include a valuation of present assets, based on statement value, and prospective assets and liabilities of the plan and the extent of any unfunded accrued liabilities.
2. A plan to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities.
3. A description and explanation of actuarial assumptions.
4. A schedule illustrating the amortization of any unfunded liabilities.

5. A comparative review illustrating the level of funds available to the commercial self-insurance fund from rates, investment income, and other sources realized over the period covered by the report, indicating the assumptions used.
6. A projection of the following year's plan of operation, including additional number of members, gross premiums to be written, and projected liabilities.
7. A statement by the actuary that the report is complete and accurate and that in her or his opinion the techniques and assumptions used are reasonable and meet the requirements of this subsection.
8. Other factors or statements as may be reasonably required by the office or commission in order to determine the actuarial soundness of the plan.
(c) Any changes in the constitution, bylaws, or trust agreement of the fund.

624.474 Assessments.—
(1) The trustees of a self-insurance fund operating as a trust, or the corporate directors of a self-insurance fund operating as a corporation, may assess from time to time members of a self-insurance fund liable therefor under the terms of their policies and pursuant to this section, or the department may assess the members in the event of liquidation of the fund.
(2) Subject to the limitations of s. 624.472(1), each member's share of a deficiency for which an assessment is made shall be computed by applying to the premium earned on the member's policy or policies during the period to be covered by the assessment the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment. In the event one or more members fail to pay an assessment, the other members are liable on a proportionate basis for an additional assessment. The fund, acting on behalf of all members who paid the additional assessment, shall institute legal action when necessary and appropriate to recover the assessment from members who failed to pay it.
(3) In computing the earned premiums for the purposes of this section, the gross premium received by the fund for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.
(4) No member shall have an offset against any assessment for which she or he is liable on account of any claim for unearned premium or losses payable.

624.488 Applicability of related laws.—In addition to other provisions of the code cited in ss. 624.460-624.488:
(1) Sections 624.155, 624.308, 624.414, 624.415, and 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); and s. 624.501;
(2) Parts I, II, and III of chapter 625;
(3) Applicable sections of part VI of chapter 626; s. 626.9541(1)(a), (b), (c), (d), (e), (f), (h), (i), (j), (k), (l), (m), (n), (o), (q), (u), (w), and (x); and ss. 626.9561-626.9641;
(4) Sections 627.291, 627.413, 627.4132, 627.416, 627.418, 627.420, 627.421, 627.425, 627.426, 627.4265, 627.427, 627.428, 627.702, and 627.706; part XI of chapter 627; ss. 627.912, 627.913, and 627.918;
(5) Section 628.361(2) and s. 628.6014; and
(6) Parts I and V of chapter 631,
apply to self-insurance funds. Only those sections of the code that are expressly and specifically cited in ss. 624.460-624.489 apply to self-insurance funds.

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634.402 Powers of department, commission, and office; rules.—The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to service warranty associations and service warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.436, but shall not enlarge upon or extend the provisions of that section.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers

subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified

public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

634.405 Required deposit or bond.—
(1) To assure the faithful performance of its obligations to its members or subscribers in the event of insolvency, each service warranty association shall, before the issuance of its license by the office and during such time as the association may have premiums in force in this state, deposit and maintain with the department securities of the type eligible for deposit by insurers under s. 625.52. Whenever the market value of the securities deposited with the department is less than 95 percent of the amount required, the association shall deposit additional securities or otherwise increase the deposit to the amount required. Such securities shall have at all times a market value as follows:
(a) Warrantors.—
1. Any warrantor which:
a. Was licensed under this part before October 1, 1983;
b. Was transacting service warranty business in this state before June 14, 1978;
c. Has continuously transacted service warranty business in this state since June 14, 1978; and
d. Has not during any year since June 14, 1978, written more than $100,000 of gross written premiums,

shall place and maintain in trust with the department an amount equal to 50 percent of the gross written premiums in force.

2. A warrantor which has $300,000 or less of gross written premiums in this state and to which the provisions of subparagraph 1. do not apply shall place and maintain in trust with the department an amount not less than $50,000. A new warrantor, before the issuance of its license and before receiving any premiums, shall place and maintain in trust with the department the amount of $50,000.
3. A warrantor which has more than $300,000 but less than $750,000 of gross written premiums in this state shall place and maintain in trust with the department an amount not less than $75,000.
4. A warrantor which has $750,000 or more of gross written premiums in this state shall place and maintain in trust with the department an amount equal to $100,000.
5. All warrantors, upon receipt of written notice from the office, shall have 30 calendar days in which to make additional deposits.
(b) Warranty sellers.—A warranty seller shall, before the issuance of its license, place in trust with the department an amount not less than $100,000.

(2) In lieu of any deposit of securities required under subsection (1) and subject to the approval of the office, the service warranty association may file with the office a surety bond issued by an authorized surety insurer. The bond shall be for the same purpose as the deposit in lieu of which it is filed. The office may not approve any bond under the terms of which the protection afforded against insolvency is not equivalent to the protection afforded by those securities provided for in subsection (1). When a bond is deposited in lieu of the required securities, no warranties may be written which provide coverage for a time period beyond the duration of such bond. The bond shall guarantee that the service warranty association will faithfully and truly perform all the conditions of any service warranty contract. No such bond may be canceled or subject to cancellation unless at least 60 days' advance notice thereof, in writing, is filed with the office. In the event that notice of termination of the bond is filed with the office, the service warranty association insured thereunder shall, within 30 days of the filing of notice of termination, provide the office with a replacement bond meeting the requirements of this part or deposit additional securities as required under subsection (1). The cancellation of a bond will not relieve the obligation of the issuer of the bond for claims arising out of contracts issued before cancellation of the bond unless a replacement bond or securities are filed. In no event may the liability of the issuer under the bond exceed the face amount of the bond. If within 30 days of filing the notice of termination no replacement bond or additional security is provided, the office shall suspend the license of the association until the deposit requirements are satisfied.
(3) Securities and bonds posted by an association pursuant to this section are for the benefit of, and subject to action thereon in the event of insolvency or impairment of any association or insurer by, any person or persons sustaining an actionable injury due to the failure of the association to faithfully perform its obligations to its warranty holders.
(4) The state is responsible for the safekeeping of all securities deposited with the department under this part. Such securities are not, on account of being in this state, subject to taxation, but shall be held exclusively and solely to guarantee the faithful performance by the association of its obligations to its members or subscribers.
(5) The depositing association shall, during its solvency, have the right to exchange or substitute other securities of like quality and value for securities on deposit, to receive the interest and other income accruing to such securities, and to inspect the deposit at all reasonable times.
(6) Such deposit or bond shall be maintained unimpaired as long as the association continues in business in this state. Whenever the association ceases to do business in this state and furnishes the office proof satisfactory to the office that it has discharged or otherwise adequately provided for all its obligations to its members or subscribers in this state, the office and department shall release the deposited securities to the parties entitled thereto, on presentation of the receipts of the department for such securities, or shall release any bond filed with it in lieu of such deposit.
(7) Any business, or its affiliate, whose primary source of income is the sale of goods to the final consumer and derives more than 50 percent of its revenue through such sales and maintains a net worth of $100 million, as evidenced by either filing a form 10-K or other similar statement with the Securities and Exchange Commission or which has an annual financial statement that is audited and certified by an independent public accounting firm, shall be presumed to have complied with this subsection if such forms or statement are filed with the office.

634.407 Application for and issuance of license.—
(1) An application for license as a service warranty association shall be made to, and filed with, the office on printed forms as prescribed by the commission and furnished by the office.

(2) In addition to information relative to its qualifications as required under s. 634.404, the commission may require that the application show:
(a) The location of the applicant's home office.
(b) The name and residence address of each director, officer, and 10-percent or greater stockholder of the applicant.
(c) Such other pertinent information as may be required by the commission.
(3) The commission may require that the application, when filed, be accompanied by:
(a) A copy of the applicant's articles of incorporation, certified by the public official having custody of the original, and a copy of the applicant's bylaws, certified by the applicant's secretary.
(b) A copy of the most recent financial statement of the applicant, verified under oath of at least two of its principal officers.
(c) A license fee in the amount of $200, as required under s. 634.403.
(4) Upon completion of the application for license, the office shall examine the application and make such further investigation of the applicant as it deems advisable. If it finds that the applicant is qualified therefor, the office shall issue to the applicant a license as a service warranty association. If the office does not find the applicant to be qualified, it shall refuse to issue the license and shall give the applicant written notice of such refusal, setting forth the grounds therefor.

634.408 License continuance.—A license issued under this part shall continue in force as long as the service warranty association is entitled thereto under this part and until suspended, revoked, or terminated at the request of the service warranty association. However, to continue the license, annually in conjunction with the March 1 filing of the annual statement, each service warranty association shall file a $200 license fee.

634.4085 Acquisition.—Except for manufacturers as defined in this part, every service warranty association shall be subject to the provisions of s. 628.4615.

634.415 Tax on premiums; annual statement; reports.—
(1) In addition to the license fees provided in this part for service warranty associations and license taxes as provided in the insurance code as to insurers, each such association and insurer shall, annually on or before March 1, file with the office its annual statement, in the form prescribed by the commission, showing all premiums or assessments received by it in connection with the issuance of service warranties in this state during the preceding calendar year and using accounting principles which will enable the office to ascertain whether the financial requirements set forth in s. 634.406 have been satisfied.
(2) The gross amount of premiums and assessments is subject to the sales tax imposed by s. 212.0506.
(3) The office may levy a fine of up to $100 a day for each day an association neglects to file the annual statement in the form and within the time provided by this part. The amount of the fine shall be established by rules adopted by the commission. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.
(4) The office may suspend or revoke the license of a service warranty association failing to file its annual statement when due.
(5) The commission may by rule require each service warranty association to submit to the office, as the commission may designate, all or part of the information contained in the financial statements and reports required by this section in a computer-readable form compatible with the electronic data processing system specified by the office.

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624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

642.032 Provisions of general insurance law applicable to legal expense insurance corporations.—The following provisions of the Florida Insurance Code shall apply to legal expense insurance corporations, to the extent that they are not inconsistent with the provisions of ss. 642.011-642.049:
(1) Chapter 624, administration and general provisions.
(2) Chapter 625, accounting, investments, and deposits.
(3) Chapter 626, part IX, unfair insurance trade practices.
(4) Chapter 627, part I, rates and rating organizations, and part II, the insurance contract.
(5) Section 628.4615, specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.
(6) Chapter 631, insurer insolvency; guaranty of payment.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.4211 Administrative fine in lieu of suspension or revocation.—

(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the

commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer

to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is

immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

626.681 Administrative fine in lieu of or in addition to suspension, revocation, or refusal of license, appointment, or disapproval.—
(1) Except as to insurance agencies, if the department finds that one or more grounds exist for the suspension, revocation, or refusal to issue, renew, or continue any license or appointment issued under this chapter, or disapproval of a continuing education course provider, instructor, school official, or monitor groups, the department may, in its discretion, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, or disapproval, and except on a second offense or when such suspension, revocation, or refusal is mandatory, impose upon the licensee, appointee, course provider, instructor, school official, or monitor group an administrative penalty in an amount up to $500 or, if the department has found willful misconduct or willful violation on the part of the licensee, appointee, course provider, instructor, school official, or monitor group up to $3,500. The administrative penalty may, in the discretion of the department, be augmented by an amount equal to any commissions received by or accruing to the credit of the licensee or appointee in connection with any transaction as to which the grounds for suspension, revocation, or refusal related.

(2) With respect to insurance agencies, if the department finds that one or more grounds exist for the suspension, revocation, or refusal to issue, renew, or continue any license issued under this chapter, the department may, in its discretion, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, impose upon the licensee an administrative penalty in an amount not to exceed $10,000 per violation. The administrative penalty may, in the discretion of the department, be augmented by an amount equal to any commissions received by or accruing to the credit of the licensee in connection with any transaction as to which the grounds for suspension, revocation, or refusal related.
(3) The department may allow the licensee, appointee, or continuing education course provider, instructor, school official, or monitor group a reasonable period, not to exceed 30 days, within which to pay to the department the amount of the penalty so imposed. If the licensee, appointee, course provider, instructor, school official, or monitor group fails to pay the penalty in its entirety to the department within the period so allowed, the license, appointments, approval, or status of that person shall stand suspended or revoked or issuance, renewal, or continuation shall be refused, as the case may be, upon expiration of such period.

626.894 Administrative fine in lieu of suspension or revocation.—

(2) With respect to any nonwillful violation, such fine may not exceed $1,000 per violation. In no event may such fine exceed an aggregate amount of $5,000 for all nonwillful violations arising out of the same action. When an administrator discovers a nonwillful violation, the administrator shall correct the violation and, if restitution is due, the restitution shall include interest at the rate of 12 percent per year from either the date of the violation or the date of inception of the policy of the affected person, at the option of the administrator. The restitution may be a credit against future premiums due, provided that the interest shall accumulate until the premiums are due. If the amount of restitution due to any person is $50 or more, and the administrator wishes to credit it against future premiums, the administrator shall notify such person that he or she may receive a check instead of a credit. If the credit is on a policy which is not renewed, the administrator shall pay the restitution to the person to whom it is due.

634.021 Powers of department, commission, and office; rules.—The office shall administer this act and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act related to motor vehicle service agreement companies and motor vehicle service agreements. The department shall administer this act and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this act related to sales representatives.

634.301 Definitions.—As used in this part, the term:
(1) "Gross written premiums" means the total amount of premiums, paid for the entire period of the home warranty, inclusive of commissions, for which the association is obligated under home warranties issued.
(2) "Home warranty" or "warranty" means any contract or agreement whereby a person undertakes to indemnify the warranty holder against the cost of repair or replacement, or actually furnishes repair or replacement, of any structural component or appliance of a home, necessitated by wear and tear or an inherent defect of any such structural component or appliance or necessitated by the failure of an inspection to detect the likelihood of any such loss. However, this part does not prohibit the giving of usual

performance guarantees by either the builder of a home or the manufacturer or seller of an appliance, as long as no identifiable charge is made for such guarantee. This part does not permit the provision of indemnification against consequential damages arising from the failure of any structural component or appliance of a home, which practice constitutes the transaction of insurance subject to all requirements of the insurance code. This part does not apply to service contracts entered into between consumers and nonprofit organizations or cooperatives the members of which consist of condominium associations and condominium owners and which perform repairs and maintenance for appliances or maintenance of the residential property. This part does not apply to a contract or agreement offered by a warranty association in compliance with part III, provided such contract or agreement only relates to the systems and appliances of the covered residential property and does not cover any structural component of the residential property.
(3) "Home warranty association" means any corporation or any other organization, other than an authorized insurer, issuing home warranties.
(4) "Impaired" means having liabilities in excess of assets.
(5) "Insolvent" means the inability of a corporation to pay its debts as they become due in the usual course of its business.
(6) "Insurance code" means the Florida Insurance Code.
(7) "Insurer" means any property or casualty insurer duly authorized to transact such business in this state.
(8) "Listing period" means the period of time residential property is listed for sale with a licensed real estate broker, beginning on the date the residence is first listed for sale and ending on either the date the sale of the residence is closed, the date the residence is taken off the market, or the date the listing contract with the real estate broker expires.
(9) "Net assets" means the amount by which the total statutory assets of an association exceed the total liabilities of the association.
(10) "Person" includes an individual, company, corporation, association, insurer, agent, and every other legal entity.
(11) "Premium" means the total consideration received, or to be received, by an insurer or home warranty association for or related to the issuance and delivery of any binder or warranty, including any charges designated as assessments or fees for policies, surveys, inspections, or service or any other charges.
(12) "Sales representative" means any person with whom an insurer or home inspection or warranty association has a contract and who is utilized by such insurer or association for the purpose of selling or issuing home warranties. The term includes all employees of an insurer or association engaged directly in the sale or issuance of home warranties.
(13) "Structural component" means the roof, plumbing system, electrical system, foundation, basement, walls, ceilings, or floors of a home.

634.402 Powers of department, commission, and office; rules.—The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to service warranty associations and service warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.436, but shall not enlarge upon or extend the provisions of that section.

634.313 Tax on premiums; annual statement; reports.—

(3) Any association or insurer neglecting to file the annual statement in the form and within the time provided by this section shall forfeit up to $100 for each day during which

such neglect continues; and, upon notice by the office to that effect, its authority to do business in this state shall cease while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.

634.415 Tax on premiums; annual statement; reports.—

(3) The office may levy a fine of up to $100 a day for each day an association neglects to file the annual statement in the form and within the time provided by this part. The amount of the fine shall be established by rules adopted by the commission. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.

641.26 Annual and quarterly reports.—

(3) Every health maintenance organization shall file quarterly, for the first three calendar quarters of each year, an unaudited financial statement of the organization as described in paragraphs (1)(a) and (b). The statement for the quarter ending March 31 shall be filed on or before May 15, the statement for the quarter ending June 30 shall be filed on or before August 15, and the statement for the quarter ending September 30 shall be filed on or before November 15. The quarterly report shall be verified by the oath of two officers of the organization, properly notarized.

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

641.403 Rulemaking authority.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part.

641.41 Annual report of prepaid health clinic; administrative penalty.—

(2) Any clinic which neglects to file the annual report in the form and within the time required by this section is subject to an administrative penalty, not to exceed $100 for each day during which the neglect continues; and, upon notice by the office to that effect, the authority of the clinic to do business in this state shall cease while such default continues.

642.0338 Administrative fine in lieu of suspension or revocation.—

(2) With respect to any nonwillful violation, such fine shall not exceed $1,000 per violation. In no event shall such fine exceed an aggregate amount of $5,000 for all nonwillful violations arising out of the same action. When an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that the interest on the restitution will accumulate until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, the insurer shall notify such person that it wishes to do so but that the

person may receive a check instead of a credit. If the credit is on a policy which is not renewed, the insurer shall pay the restitution to the person to whom it is due.

651.015 Administration; forms; fees; rules; fines.—The administration of this chapter is vested in the commission, office, and department, which shall:
(1) Prepare and furnish all forms necessary under the provisions of this chapter in relation to applications for provisional certificates of authority, certificates of authority or renewals thereof, statements, examinations, and other required reports. The office is authorized to accept any application statement, report, or information submitted electronically or by facsimile to comply with requirements in this chapter or rules adopted under this section. The commission may adopt rules to implement the provisions of this subsection.
(2) Collect in advance, and the applicant shall pay in advance, the following fees:
(a) At the time of filing an application for a certificate of authority, an application fee in the amount of $75 for each facility.
(b) At the time of filing the annual report required by s. 651.026, a fee in the amount of $100 for each year or part thereof for each facility.
(c) A late fee not to exceed $50 a day for each day of noncompliance.
(d) A fee to cover the actual cost of a credit report and fingerprint processing.
(e) At the time of filing an application for a provisional certificate of authority, a fee in the amount of $50.
(3) Adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter.
(4) Impose administrative fines and penalties pursuant to this chapter.
(5) Deposit all fees and fines collected under the provisions of this chapter into the Insurance Regulatory Trust Fund.

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624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

627.8405 Prohibited acts; financing companies.—No premium finance company shall, in a premium finance agreement or other agreement, finance the cost of or otherwise provide for the collection or remittance of dues, assessments, fees, or other periodic payments of money for the cost of:
(1) A membership in an automobile club. The term "automobile club" means a legal entity which, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, this definition of "automobile club" does not include persons, associations, or corporations which are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon racecourses established and marked as such for the duration of such particular events. The words "motor vehicle" used herein have the same meaning as defined in chapter 320.
(2) An accidental death and dismemberment policy sold in combination with a personal injury protection and property damage only policy.
(3) Any product not regulated under the provisions of this insurance code.
This section also applies to premium financing by any insurance agent or insurance company under part XVI. The commission shall adopt rules to assure disclosure, at the time of sale, of coverages financed with personal injury protection and shall prescribe the form of such disclosure.

624.321 Witnesses and evidence.—
(1) As to any examination, investigation, or hearing being conducted under this code, a person designated by the department or office, respectively:
(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence;

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial

statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements

of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.

3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.80 Definitions.—As used in this part:

(1) "Insurer" means and includes every person as defined in s. 624.03 as limited to:

(a) Any domestic or commercially domiciled insurer who is doing business as an insurer, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.
(b) Any specialty insurer as that term is defined in s. 628.4615.
(c) Any domestic or commercially domiciled fraternal benefit society which is subject to the provisions of chapter 632.
(2) "Unsound condition" means that the office has determined that one or more of the following conditions exist with respect to an insurer:
(a) The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
(b) The insurer continues to write new business when it has not maintained the required surplus or capital;
(c) The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the office, for liabilities arising from insurance policies issued by the insurer; or
(d) The insurer meets one or more of the grounds in s. 631.051 for the appointment of the department as receiver.
(3) "Exceeded its powers" means the following conditions:
(a) The insurer has refused to permit examination by the office of its books, papers, accounts, records, or business practices;
(b) An insurer organized in this state has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer by the office;
(c) The insurer has failed to promptly comply with the applicable financial reporting statutes and office requests relating thereto;
(d) The insurer has neglected or refused to observe an order of the office to correct a deficiency in its capital or surplus; or
(e) The insurer has unlawfully or in violation of an office order:
1. Totally reinsured its entire outstanding business; or
2. Merged or consolidated substantially its entire property or business with another insurer.
(4) "Consent" means authorized written agreement to supervision by the insurer.
(5) "Commercially domiciled insurer" means and includes any foreign or alien insurer which, during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been licensed to transact its business in this state only for the lesser period of time, has written an average of 25 percent or more direct premiums in this state than it has written in its state of domicile during the same period, or the direct premiums written in this state constitute more than 55 percent of its total direct premiums written everywhere in the United States during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been authorized to transact its business in this state only for the lesser period of time, as reported in its most recent applicable annual or quarterly statements.

624.81 Notice to comply with written requirements of office; noncompliance.—
(1) If the office determines that the conditions set forth in subsection (2) exist, the office shall issue an order placing the insurer in administrative supervision, setting forth the reasons giving rise to the determination, and specifying that the office is applying and effectuating the provisions of this part. An order issued by the office pursuant to this subsection entitles the insurer to request a proceeding under ss. 120.569 and 120.57, and such a request shall stay the action pending such proceeding.

(2) An insurer shall be subject to administrative supervision by the office if upon examination or at any other time the office determines that:
(a) The insurer is in unsound condition;
(b) The insurer's methods or practices render the continuance of its business hazardous to the public or to its insureds; or
(c) The insurer has exceeded its powers granted under its certificate of authority and applicable law.
(3) Within 15 days of receipt of notice of the office's determination to proceed under this part, an insurer shall submit to the office a plan to correct the conditions set forth in the notice. For good cause shown, the office may extend the 15-day time period for submission of the plan. If the office and the insurer agree on a corrective plan, a written agreement shall be entered into to carry out the plan.
(4) If an insurer fails to timely submit a plan, the office may specify the requirements of a plan to address the conditions giving rise to imposition of administrative supervision under this part. In addition, failure of the insurer to timely submit a plan is a violation of the provisions of this code punishable in accordance with s. 624.418.
(5) The plan shall address, but shall not be limited to, each of the activities of the insurer's business which are set forth in s. 624.83.
(6) Any insurer subject to administrative supervision is expected to avail itself of all reasonably available reinsurance. Reasonably available reinsurance shall include unrealized reinsurance, which is defined as reinsurance recoverable on known losses incurred and due under valid reinsurance contracts that have not been identified in the normal course of business and have not been reported in financial statements filed with the Office of Insurance Regulation. Within 90 days of being placed under administrative supervision, the insurer shall certify to the Director of the Office of Insurance Regulation that the insurer has engaged an independent third party to search for unrealized reinsurance, and that the insurer has made all relevant books and records available to the third party. The compensation to the third party may be a percentage of unrealized reinsurance identified and collected.
(7) If the office and the insurer are unable to agree on the provisions of the plan, the office may require the insurer to take such corrective action as may be reasonably necessary to remove the causes and conditions giving rise to the need for administrative supervision.
(8) The insurer shall have 60 days, or a longer period of time as designated by the office but not to exceed 120 days, after the date of the written agreement or the receipt of the office's plan within which to comply with the requirements of the office. At the conclusion of the initial period of supervision, the office may extend the supervision in increments of 60 days or longer, not to exceed 120 days, if conditions justifying supervision exist. Each extension of supervision shall provide the insurer with a point of entry pursuant to chapter 120.
(9) The initiation or pendency of administrative proceedings arising from actions taken under this section shall not preclude the office from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation or initiating other delinquency proceedings however designated under the laws of this state.
(10) If it is determined that the conditions giving rise to administrative supervision have been remedied so that the continuance of its business is no longer hazardous to the public or to its insureds, the office shall release the insurer from supervision.
(11) The commission may adopt rules to define standards of hazardous financial condition and corrective action substantially similar to that indicated in the National Association of Insurance Commissioners' 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition," which are necessary to implement the provisions of this part.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:
(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, comparison, or property and casualty certificate of insurance altered after being issued, which:
1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.
6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

627.734 Proof of security; security requirements; penalties.—
(1) The provisions of chapter 324 which pertain to the method of giving and maintaining proof of financial responsibility and which govern and define a motor vehicle liability policy shall apply to filing and maintaining proof of security required by ss. 627.730-627.7405.
(2) Any person who:
(a) Gives information required in a report or otherwise as provided for in ss. 627.730-627.7405, knowing or having reason to believe that such information is false;
(b) Forges or, without authority, signs any evidence of proof of security; or
(c) Files, or offers for filing, any such evidence of proof, knowing or having reason to believe that it is forged or signed without authority,
is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

627.828 License required.—
(1) Except as provided in ss. 627.901 and 627.902, no person shall engage in the business of a premium finance company unless licensed by the office. Every premium finance company licensed under the provisions of this part shall maintain at all times a net worth of $35,000. However, in lieu of having a net worth of $35,000, a premium finance company that has a net worth of $10,000 may file a surety bond with the office or other acceptable collateral with the department as approved by the office or department in the amount of $35,000, which bond or collateral must be maintained.
(2) The application for a license shall be in writing and in the form prescribed by the commission. Every applicant shall provide evidence of a net worth of $35,000 attested by two officers of the company, or a $35,000 surety bond and evidence of a net worth of

$10,000 attested by two officers of the company. Assets to be used in computing the required net worth shall be determined by rules adopted by the commission.
(3)(a) Each premium finance company authorized under the provisions of this part shall maintain at all times an errors and omissions insurance policy of no less than $500,000 covering the acts of its officers, employees, and agents. The policy may contain reasonable deductibles not to exceed 2 percent of the policy limits.
(b)1. A premium finance company with an unencumbered net worth of at least $15 million may self-insure the errors and omissions coverage if it meets the requirements of this paragraph.
2. To qualify as a self-insurer the premium finance company must:
a. Have and maintain an unencumbered net worth of $15 million, which shall be determined based on assets permissible for insurers pursuant to ss. 625.012 and 625.031;
b. Annually demonstrate as part of its annual report, to the satisfaction of the department, that the net-worth requirement is being met; and
c. Obtain, as a part of its annual application for licensure as a premium finance company, a certificate of self-insurance from the office to be renewed annually.
3. If the office finds that the premium finance company:
a. Is not maintaining at all times an unencumbered net worth of at least $15 million; or
b. Is not, in good faith, covering the errors and omissions of its officers, employees and agents,

the office shall, in addition to other penalties under this code, revoke or suspend the certificate of self-insurance, and the premium finance company shall be subject to the requirements of paragraph (a).

(c) The commission may adopt rules necessary to administer this subsection, including rules prescribing the necessary forms.
(4) A single license shall entitle the holder to operate more than one office.
(5) At the time of filing an application for a license, the applicant shall pay to the office the license fee and, upon original application or upon application subsequent to denial of application, or revocation, suspension or surrender of a license, an investigation fee.
(6) Such license shall state the name and address of the licensee, and a copy shall be kept conspicuously posted in each office of the licensee and shall not be transferable or assignable.
(7) Prior to moving an existing office to another location, a licensee shall notify the office in writing of its intention to do so.

627.829 Approval, disapproval of application; license renewal.—
(1) The office shall issue the license, unless it finds that the management of the premium finance company filing the application is so lacking in managerial experience as to make the proposed operation hazardous to the insurance-buying public or unless it has good reason to believe the management of the premium finance company is affiliated directly or indirectly through ownership, control, or in other business relations with any person whose business operations are or have been marked as detrimental to the public, policyholders, stockholders, investors, or creditors by manipulation of assets or of accounts or by bad faith.
(2) If the office refuses to issue a license, it shall notify the applicant of the denial and return to the applicant the sum paid as a license fee, but shall retain the investigation fee to cover the costs of investigating the applicant.
(3) Each license shall remain in force until September 30 of the year for which issued, unless earlier surrendered, suspended, or revoked, and may be renewed for the ensuing license year upon the filing of an application therefor. If an application for renewal is filed

with the office before October 1 of any year, the license sought to be renewed shall be continued in force either until the issuance by the office of the renewal license applied for or until 5 days after the office refuses to renew the license.

627.832 Grounds for refusal, suspension, or revocation of license.—
(1) The office may deny, suspend, revoke, or refuse to renew any license, if it finds:
(a) That the licensee has failed to pay the annual license fee or any sum of money lawfully demanded under authority of any other section of this part or has failed to comply with any order of the office.
(b) That the licensee has violated any provision of this part or any rule of the commission.
(c) That any fact or condition exists which, if it had existed at the time of the original application, clearly would have warranted a refusal to issue the license.
(d) Material misstatement, misrepresentation, or fraud in obtaining the license or permit, or in attempting to obtain the license or permit.
(e) That the license or permit is being willfully used, or is to be used, to circumvent any of the requirements or prohibitions of this code.
(f) Willful misrepresentation of any premium finance contract or willful deception with regard to any such contract, accomplished either in person or by any form of dissemination of information.
(g) A demonstrated lack of fitness or trustworthiness.
(h) Fraudulent or dishonest practices in the conduct of business.
(i) Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers, insureds, or beneficiaries or to others and received in the conduct of business.
(j) That the licensee has been found guilty of, or has pleaded guilty to, a felony in this state or any other state.
(2) A licensee may surrender a license by delivering to the office written notice that she or he thereby surrenders such license, but such surrender shall not affect such licensee's civil or criminal liability for acts committed prior to such surrender.
(3) No revocation, suspension, or surrender of a license shall impair or affect the obligation of any insured under any lawful premium finance agreement previously acquired or held by the licensee.
(4) Every license issued hereunder shall remain in force and effect until it has been surrendered, revoked, or suspended or expires in accordance with the provisions of this part; but the office may reinstate a suspended license or issue a new license to a licensee whose license has been revoked, if no fact or condition then exists which clearly would have warranted office refusal originally to issue such license under this part.

627.834 Examinations.—
(1) The office may conduct examinations and investigations of premium finance companies under the provisions of ss. 624.307 and 626.601.
(2) As often as it deems necessary and not less frequently than each 3 years, the office shall examine each licensed premium finance company. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of this code

627.836 Licensee's books and records; reports.—
(1) The licensee shall keep and use in her or his business such books, accounts, and records as will enable the office to determine whether the licensee is complying with the provisions of this part and with the rules pertaining thereto. Every licensee shall preserve such books, accounts, and records, including cards used in a card system, if any, for at least

3 years after making the final entry in respect to any premium finance agreement recorded therein; however, the preservation of photographic reproductions thereof or records in photographic form shall constitute compliance with this requirement.
(2) Each licensee shall annually, on or before March 1, file a report with the office giving such information as the office may require. The report shall be made under oath and in the form prescribed by the commission and shall be accompanied by the annual report filing fee specified in s. 627.849. The office may make and publish annually an analysis and recapitulation of such reports. In addition, the office may require such additional regular or special reports as it deems necessary. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission.

627.838 Filing and approval of forms; service charges.—
(1) No premium finance agreement form or related form shall be used in this state by a premium finance company unless it has been filed with and approved by the office. Every filing shall be made within 30 days of issuance or use.
(2) Each premium finance company shall file with the office the service charge and interest rate plan, including all modifications thereto, for informational purposes only. Every filing shall be made within 30 days of its effective date.

627.840 Limitation on service and other charges.—
(1) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this part.
(2) A premium finance company may, in a premium finance agreement, contract for, charge, receive, and collect a service charge for financing the premiums under the agreement computed as provided in subsection (3).
(3)(a) The service charge provided for in this section shall be computed on the balance of the premiums due, after subtracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which the premiums are being advanced to and including the date when the final payment of the premium finance agreement is payable.
(b) The service charge shall be a maximum of $12 per $100 per year plus an additional charge not exceeding $20, which additional charge need not be refunded upon prepayment. Such additional charge may be charged only once in a 12-month period for any one customer unless that customer's policy has been canceled due to nonpayment within the immediately preceding 12-month period. However, any insured may prepay her or his premium finance agreement in full at any time before the due date of the final payment; and in such event the unearned service charge shall be refunded in accordance with the "Rule of 78ths," or any other method at least as beneficial to the insured and approved by the office, and shall represent at least as great a proportion of the service charge, if any, as the sum of the periodic balances after the month in which prepayment is made bears to the sum of all periodic balances under the schedule of payments in the agreement. When the amount of the refund is less than $1, no refund need be made if the agreement so states.
(c) Such service charge shall be inclusive of all charges incident to the premium finance agreement and for the extension of credit provided for therein.
(d) Paragraphs (a)-(c) apply if the premiums under only one insurance contract are advanced or to be advanced under a premium finance agreement; if premiums under more than one insurance contract are advanced or to be advanced under a premium finance agreement, the service charge shall be computed from the inception date of such insurance

contracts, or from the due date of such premiums; however, not more than one minimum service charge shall apply to each premium finance agreement.
(e) No insurance agent or premium finance company shall induce an insured to become obligated under more than one premium finance agreement for the purpose of obtaining more than one minimum service charge.

627.841 Delinquency, collection, cancellation, and check return charges; attorney's fees.—
(1) A premium finance agreement may provide for the payment by the insured of a delinquency and collection charge on each installment in default for a period of not less than 5 days in an amount not to exceed $10 or 5 percent of the delinquent installment, whichever is greater; provided that if the premium finance agreement is primarily for personal, family, or household purposes, the delinquency and collection charge shall not exceed $10. Only one such delinquency and collection charge may be collected on any such installment regardless of the period during which it remains in default.
(2) A premium finance agreement may also provide for the payment of attorney's fees not exceeding 20 percent of the amount due and payable under the agreement if it is referred for collection to an attorney not a salaried employee of the premium finance company holding the agreement.
(3) Notwithstanding the provisions of this section, a premium finance company shall not take, receive from, or charge an insured any cancellation charge or attorney's fees unless, within 10 days after default in the payment of any installment of a premium finance agreement, the premium finance company has mailed a notice of the default to the insured at her or his address as shown on the agreement and to any insurance agent named therein at her or his place of business as shown giving the insured at least 5 days within which to make the payment in default.
(4) In the event that a payment is made to a premium finance company by check or draft and the instrument is returned because of insufficient funds to pay it, the premium finance company may, if the premium finance agreement so provides, impose a charge of $15.

627.844 Assignment of premium finance agreement.—
(1) A premium finance company may purchase or otherwise acquire a premium finance agreement from another premium finance company with recourse against the other premium finance company on such terms and conditions as may be mutually agreed upon.
(2) No filing of an assignment or notice thereof to the insured shall be necessary to the validity of the written assignment of a premium finance agreement as against creditors or subsequent purchasers, pledgees, or encumbrancers of the assignor.
(3) Unless the insured has notice of an actual or intended assignment of a premium finance agreement, payment thereunder by the insured to the last known holder of the agreement shall be binding upon all subsequent holders or assignees.

627.845 Statement of account; receipts.—
(1) At any time after the execution of a premium finance agreement, but not later than 1 year after the last payment thereunder, the premium finance company holding the premium finance agreement shall, upon written request of the insured, give or mail to her or him a written statement of the dates and amounts of payments and the total amount, if any, unpaid thereunder. A statement shall be supplied once each year without charge; if any additional statement is requested, the premium finance company shall supply the statement at a charge not exceeding $1 for each additional statement so supplied. An insured shall be given a receipt for a payment when made in cash.
(2) After the payment of all sums for which an insured is obligated under a premium finance agreement, and upon the insured's written demand, the premium finance company holding the agreement shall deliver, or mail to the insured at her or his last known address,

such one or more good and sufficient instruments as may be necessary to acknowledge payment in full and to release all interest in or rights to the insurance contracts, the premiums for which were advanced or are to be advanced under the agreement.

627.848 Cancellation of insurance contract upon default.—
(1) When a premium finance agreement contains a power of attorney or other authority enabling the premium finance company to cancel any insurance contract listed in the agreement, the insurance contract shall not be canceled unless cancellation is in accordance with the following provisions:
(a)1. Not less than 10 days' written notice shall be mailed to each insured shown on the premium finance agreement of the intent of the premium finance company to cancel her or his insurance contract unless the defaulted installment payment is received within 10 days.
2. After expiration of such period, the premium finance company shall mail to the insurer a request for cancellation, specifying the effective date of cancellation and the unpaid premium balance due under the finance contract, and shall mail a copy thereof to the insured at her or his last known address as shown on the premium finance agreement.
(b) Every notice of cancellation shall include, in type or print of which its face shall not be smaller than 12 points, a statement that, if the insurance contract or contracts provide motor vehicle liability insurance required by the financial responsibility law, proof of financial responsibility is required to be maintained continuously for a period of 3 years, pursuant to chapter 324, and the operation of a vehicle without such financial responsibility is unlawful.
(c) Upon receipt of a copy of the cancellation notice by the insurer or insurers, the insurance contract shall be canceled as of the date specified in the cancellation notice with the same force and effect as if the notice of cancellation had been submitted by the insured herself or himself, whether or not the premium finance company has complied with the notice requirement of this subsection, without requiring any further notice to the insured or the return of the insurance contract.
(d) All statutory, regulatory, and contractual restrictions providing that the insured may not cancel her or his insurance contract unless she or he or the insurer first satisfies such restrictions by giving a prescribed notice to a governmental agency, the insurance carrier, a mortgagee, an individual, or a person designated to receive such notice for such governmental agency, insurance carrier, or individual shall apply when cancellation is effected under the provisions of this section. The insurer, in accordance with such prescribed notice when it is required to give such notice in behalf of itself or the insured, shall give notice to such governmental agency, person, mortgagee, or individual; and it shall determine and calculate the effective date of cancellation from the day it receives the copy of the notice of cancellation from the premium finance company.
(e) Whenever a financed insurance contract is canceled, the insurer shall, within 30 days of the cancellation date, return the unpaid balance due under the finance contract, up to the gross amount available upon the cancellation of the policy, to the premium finance company and any remaining unearned premium to the agent or the insured, or both, for the benefit of the insured or insureds. The insurer shall, within 30 days of the cancellation date, notify the insured and the agent of the amount of unearned premium returned to the premium finance company and the amount of unearned commission held by the agent. The premium finance company shall, within 15 days after the account has been overpaid, either refund to the insured for the insured's benefit any refund due on his or her account or, if the refund is sent or credited to the agent, return or credit to the agent the amount of the overpayment and notify the insured of the refunded amount. Within 15 days of receipt of notification from the premium finance company, the agent shall return such amount including any unearned commission to the insured or with the written approval of the insured apply such amount to the purchase of other insurance products regulated by the office. The commission may adopt rules necessary to implement the provisions of this subsection.

(f) If an insurance contract is canceled by an insurer upon the receipt of a copy of the cancellation notice from a premium finance company, and if such premium finance company has failed to provide the notice required by this subsection, the insured shall have a cause of action against the premium finance company for damages caused by such failure to provide notice.
(2) Any court of this state rendering or affirming a judgment or decree against a premium finance company and in favor of any named or omnibus insured or beneficiary arising out of a wrongful or improper cancellation of an insurance policy by such premium finance company shall award reasonable attorney's fees to the insured or beneficiary.
(3) The commission shall adopt a standard cancellation notice for use by premium finance companies in canceling insurance policies. The commission shall specify the color of the notice so as to promote usability and standardization.

627.849 Fees.—
(1) The office shall collect in advance, and the persons so served shall pay to it in advance, the following fees:
(a) Annual license fee.....$250
(b) Investigation fee.....100
(c) Annual report filing fee.....25
(2) The fees received under this section shall be credited to the Insurance Regulatory Trust Fund.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.
(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.
(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:
(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,
2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:
a. Each director, officer, or trustee, if a corporation, or
b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(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.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law 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, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10

days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the specialty insurer, sell 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, or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or

s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;
7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or

9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.

(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.

(d) For the purpose of this section, the term "natural person" means an individual.

(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.

(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs

elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period

of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.321 Witnesses and evidence.—
(1) As to any examination, investigation, or hearing being conducted under this code, a person designated by the department or office, respectively:
(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence;

636.067 Rules.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act. A violation of any such rule subjects the violator to the provisions of s. 636.048.

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount medical plan organizations; establishing standards for evaluating forms, advertisements, marketing materials, brochures, and discount cards; providing for the collection of data; relating to disclosures to plan members; and defining terms used in this part.

636.005 Incorporation required; exceptions.—
(1) On or after October 1, 1993, any entity that has not yet obtained a certificate of authority to operate a prepaid limited health service organization in this state must be incorporated.
(2) A prepaid limited health service organization may be organized as a profit or nonprofit corporation.
(3) A prepaid limited health service organization may be incorporated in another state if the entity maintains a certificate of authority or license in the state in which it is domiciled to provide services which the applicant intends to provide in this state and maintains a certificate of authority in this state.
(4) This section shall not apply to providers licensed pursuant to chapter 463 or any other licensed professional if incorporation is limited or restricted by law.

636.008 Application for certificate of authority.—Before any entity may operate a prepaid limited health service organization, it must obtain a certificate of authority from the office. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following:
(1) A copy of the applicant's basic organizational document, including the articles of incorporation, articles of association, partnership agreements, trust agreement, or other applicable documents and all amendments to such documents.
(2) A copy of all bylaws, rules, and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.
(3) A list of the names, addresses, official positions, and biographical information 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 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the prepaid limited health service organization, including any possible conflicts of interest.
(4) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under subsection (3).
(5) A statement generally describing the applicant, its facilities and personnel, and the limited health service or services to be offered.
(6) 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.
(7) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in subsection (3).
(8) 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.
(9) A copy of the form of any prepaid limited health service contract which is to be issued to employers, unions, trustees, individuals, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers.
(10) A copy of the applicant's most recent financial statements audited by an independent certified public accountant.
(11) A copy of the applicant's financial plan, including a 3-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.
(12) A schedule of rates and charges for each contract to be used which contains an opinion from a qualified independent actuary or a qualified employee that the rates are not inadequate, excessive, or discriminatory. If a prepaid limited health service organization does not employ or otherwise retain the services of an independent actuary, the chief executive officer of the prepaid limited health service organization must review and sign the certification indicating her or his agreement with its conclusions. If the office determines that, based upon documents filed with the office, the qualified employee is not qualified, the organization shall retain the services of a qualified independent actuary.
(13) A description of the proposed method of marketing.
(14) A description of the subscriber complaint procedures to be established and maintained as required under s. 636.038.
(15) A description of how the applicant will comply with s. 636.046.
(16) The fee for issuance of a certificate of authority as provided in s. 636.057.
(17) Such other information as the commission or office may reasonably require to make the determinations required by this act.
The office shall issue a certificate of authority which shall expire on June 1 each year and which the office shall renew if the applicant pays the license fees provided in s. 636.057 and if the office is satisfied that the organization is in compliance with this act.

636.009 Issuance of certificate of authority; denial.—
(1) Following receipt of an application filed pursuant to s. 636.008, the office shall review such application and notify the applicant of any deficiencies contained therein. The office shall issue a certificate of authority to an applicant who has filed a completed application in

conformity with s. 636.008, upon payment of the fees specified by s. 636.057 and upon the office being satisfied that the following conditions are met:
(a) The requirements of s. 636.008 have been fulfilled.
(b) The entity is actuarially sound.
(c) The entity has met the applicable minimum surplus requirements specified in s. 636.045.
(d) The procedures for offering limited health services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status. However, this paragraph does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit prospective experience rating.
(e) The entity furnished evidence of adequate insurance coverage, including, but not limited to, general liability or professional liability coverage, or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing covered services.
(f) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The office shall not grant or continue authority to transact the business of a prepaid limited health service organization in this state at any time during which the office has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.
(g) The entity has demonstrated compliance with s. 636.047 by obtaining a blanket fidelity bond in the amount of at least $50,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds. All employees handling the funds must be covered by the blanket fidelity bond. However, the fidelity bond need not cover an individual who owns 100 percent of the stock of the organization if such stockholder maintains total control of the organization's financial assets, books and records, and fidelity bond coverage is not available for such individual. An agent licensed under the provisions of the Florida Insurance Code may, either directly or indirectly, represent the prepaid limited health service organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any subscriber's contract, or collect or forward any consideration paid by the subscriber to the prepaid limited health service organization. The licensed agent shall not be required to post the bond required by this subsection.
(h) The prepaid limited health service organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.
(i) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the office may consider:
1. The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith.
2. The adequacy of surplus, other sources of funding, and provisions for contingencies.
3. The manner in which the requirements of s. 636.046 have been fulfilled.
(j) The agreements with providers for the provision of limited health services contain the provisions required by s. 636.035.
(k) Any deficiencies identified by the office have been corrected.
(l) All requirements of this chapter have been met.
(2) If the certificate of authority is denied, the office shall notify the applicant and shall specify the reasons for denial in the notice.

636.012 Continued eligibility for certificate of authority.—In order to maintain its eligibility for a certificate of authority, a prepaid limited health service organization must continue to meet all conditions required to be met under this act and the rules adopted thereunder for the initial application for and issuance of its certificate of authority under ss. 636.008 and 636.009.

636.016 Prepaid limited health service contracts.—For any entity licensed prior to October 1, 1993, all subscriber contracts in force at such time shall be in compliance with this section upon renewal of such contract.
(1) Any entity issued a certificate of authority and otherwise in compliance with this act may enter into contracts in this state to provide an agreed-upon set of limited health services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum.
(a) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:
1. Is in any respect in violation of, or does not comply with, any provision of this act or rule adopted thereunder.
2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. Has any title, heading, or other indication of its provisions which is misleading.
4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.
5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.
6. Charges rates that are determined by the office to be inadequate, excessive, or unfairly discriminatory, or if the rating methodology followed by the prepaid limited health service organization is determined by the office to be inconsistent with the provisions of s. 636.017.
(b) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.
(c) All contracts shall be for a minimum period of 12 months, unless the contract holder requests, in writing, a shorter contract period.
(2) Every prepaid limited health service organization shall provide each subscriber a contract, a certificate, membership card, or member handbook which must clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the prepaid limited health service organization. The contract, certificate, provider listing, or member handbook must also state where and in what manner the health services may be obtained.
(3) The documents provided pursuant to subsection (2) must have a clear and understandable description of the method used by the prepaid limited health service organization for resolving subscriber grievances and, for such documents printed after October 1, 1998, must contain the address of the department and the department's toll-free consumer hotline.
(4) The rate of payment for a prepaid limited health services contract sold on an individual basis must be a part of the contract and must be stated in individual contracts issued to subscribers.
(5) All prepaid limited health service coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children will be provided

with respect to a preenrolled newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth, or adoption pursuant to chapter 63.
(6) No alteration of any written application for any prepaid limited health services contract may be made by any person other than the applicant without his or her written consent, except that insertions may be made by the prepaid limited health service organization for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.
(7) No contract may contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to prepaid limited health service organizations.
(8) Each document provided pursuant to subsection (2) must state that emergency services, if any, will be provided to subscribers in emergency situations not permitting treatment through the prepaid limited health service organization providers, without prior notification to and approval of the organization. The prepaid limited health services document must contain a definition of emergency services, describe procedures for determination by the prepaid limited health service organization of whether the services qualify for reimbursement as emergency services, and contain specific examples of what does constitute an emergency.
(9)(a) All prepaid limited health services contracts, certificates, and member handbooks must contain the following provision:

"Grace Period: This contract has a (insert number of days, but not less than 10 days) -day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force."

(b) Paragraph (a) does not apply to certificates or member handbooks delivered to individual subscribers under a group prepaid limited health services contract when the employer who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscriber. However, such required provision applies to the group prepaid limited health services contract.
(10) The contract must clearly disclose the intent of the prepaid limited health service organization as to the applicability or nonapplicability of coverage to preexisting conditions. The contract must also disclose what services are excludable.
(11) All prepaid limited health service organization contracts which provide coverage for a member of the family of the subscriber, must, as to such family member's coverage, provide that coverage, benefits, or services applicable for children will be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement in the residence of the subscriber. In the case of a newborn child, coverage begins from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child whether or not such agreement is enforceable. However, coverage for such child is not required if the child is not ultimately adopted by the subscriber in compliance with chapter 63.
(12) Each prepaid limited health service organization shall provide prospective enrollees, upon request, with written information about the terms and conditions of the plan in accordance with subsection (2) to enable prospective enrollees to make informed decisions about accepting a managed-care system of limited health care delivery. All marketing materials printed by the prepaid limited health services organization, after October 1, 1997, must contain a notice in boldfaced type which states that the information required under this section is available to prospective enrollees upon request.
(13) Each prepaid limited health service organization shall make available to all subscribers, upon request, a description of the authorization and referral process for

services or a description of the process used to analyze the qualifications and credentials of providers under contract with the organization.

636.017 Rates and charges.—
(1) The rates charged by any prepaid limited health service organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory. The commission or office may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this section.
(2) In determining whether a rate is in compliance with subsection (1), the office must take into consideration the limited services provided, the method in which the services are provided, and the method of provider payment. This section may not be construed as authorizing the commission to establish by rule minimum loss ratios for prepaid limited health service organizations' rates.

636.018 Changes in rates and benefits; material modifications; addition of limited health services.—
(1)(a) No prepaid limited health services contract, certificate of coverage, application, enrollment form, rider, endorsement, and applicable rates to be charged may be delivered in this state unless the forms and rates have been filed with the office by or on behalf of the prepaid limited health service organization and have been approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. If a prepaid limited health service organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any rate charged for the contract or to change any basic prepaid limited health services contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form renewal certificate, it must file such changes 30 days prior to the effective date of the proposed change. At least 30 days' written notice must be provided to the subscriber before application of any approved change in rates. In the case of a group enrollee, there may be a contractual agreement with the prepaid limited health service organization to have the contract holder provide the required notice to the individual enrollees of the group. Any proposed change must contain information as required by s. 636.017.
(b) The prepaid limited health service organization's certification must be prepared by an independent actuary or a qualified employee. The chief executive officer of the prepaid limited health service organization must review and sign the certification indicating her or his agreement with its conclusions. Following receipt of notice of any disapproval or withdrawal of approval, no prepaid limited health service organization may issue or use any form disapproved by the office or as to which the office has withdrawn approval.
(2) If such filings are disapproved, the office shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization has 21 days from the date of receipt of notice to request a hearing before the office pursuant to chapter 120.

636.043 Annual, quarterly, and miscellaneous reports.—
(1) Each prepaid limited health service organization must file with the office annually, within 3 months after the end of its fiscal year, a report verified by the oath of at least two officers covering the preceding calendar year. Any organization licensed prior to October 1, 1993, shall not be required to file a financial statement, as required by paragraph (2)(a), based on statutory accounting principles until the first annual report for fiscal years ending after December 31, 1994.
(2) Such report must be on forms prescribed by the commission and must include:

(a)1. A statutory financial statement of the organization prepared in accordance with statutory accounting principles, including its balance sheet, income statement, and statement of changes in cash flow for the preceding year, certified by an independent certified public accountant, or a consolidated audited financial statement of its parent company prepared on the basis of statutory accounting principles, certified by an independent certified public accountant, attached to which must be consolidating financial statements of the parent company, including the prepaid limited health service organization.
2. Any entity subject to this chapter may make written application to the office for approval to file audited financial statements prepared in accordance with generally accepted accounting principles in lieu of statutory financial statements. The office shall approve the application if it finds it to be in the best interest of the subscribers. An application for exemption is required each year and must be filed with the office at least 2 months prior to the end of the fiscal year for which the exemption is being requested.
(b) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the prepaid limited health service organization, including any possible conflicts of interest.
(c) The number of prepaid limited health services contracts, issued and outstanding, and the number of prepaid limited health services contracts terminated.
(d) The number and amount of damage claims for medical injury initiated against the prepaid limited health service organization, and if known, any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.
(e) An actuarial report certified by a qualified independent actuary or qualified employee that:
1. The prepaid limited health service organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for, the payment of obligations of the organization.
2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.
3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.
(f) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the commission or office.
(3) Every prepaid limited health service organization which fails to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new subscribers or to do business in this state ceases while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.
(4) Each authorized prepaid limited health service organization must file a quarterly report for each calendar quarter within 45 days after the end of the quarter. The report shall contain:
(a) A financial statement prepared in accordance with statutory accounting principles. Any entity licensed before October 1, 1993, shall not be required to file a financial statement based on statutory accounting principles until the first quarterly filing after the entity files its annual financial statement based on statutory accounting principles as required by subsection (1).
(b) A listing of providers.
(c) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the commission or office.

(5) The office may require monthly reports if the financial condition of the prepaid limited health service organization has deteriorated from previous periods or if the financial condition of the organization is such that it may be hazardous to subscribers if not monitored more frequently.
(6) Each authorized prepaid limited health service organization shall retain an independent certified public accountant, hereinafter referred to as "CPA," who agrees by written contract with the prepaid limited health service organization to comply with the provisions of this act. The contract must state that:
(a) The CPA will provide to the prepaid limited health service organization audited statutory financial statements consistent with this act.
(b) Any determination by the CPA that the prepaid limited health service organization does not meet minimum surplus requirements as set forth in this act will be stated by the CPA, in writing, in the audited financial statement.
(c) The completed workpapers and any written communications between the CPA and the prepaid limited health service organization relating to the audit of the prepaid limited health service organization will be made available for review on a visual-inspection-only basis by the office at the offices of the prepaid limited health service organization, at the office, or at any other reasonable place as mutually agreed between the office and the prepaid limited health service organization. The CPA must retain for review the workpapers and written communications for a period of not less than 6 years.

636.204 License required.—
(1) Before doing business in this state as a discount medical plan organization, an entity must 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, and must be licensed by the office as a discount medical plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.
(2) An application for a license to operate as a discount medical plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:
(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.
(b) A copy of the applicant's bylaws.
(c) A list of the names, addresses, official positions, and biographical information 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 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest.
(d) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).
(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.
(f) 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.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).
(h) 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.
(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant 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 subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.
(j) A description of the proposed method of marketing.
(k) A description of the subscriber complaint procedures to be established and maintained.
(l) The fee for issuance of a license.
(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.
(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.
(4) Prior to licensure by the office, each discount medical plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.
(5) The license fee under subsection (2) is $50 per year per licensee. All amounts collected shall be deposited into the General Revenue Fund.
(6) Nothing in this part requires a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount medical plan organization.

636.218 Annual reports.—
(1) Each discount medical plan organization must file with the office, within 3 months after the end of each fiscal year, an annual report.
(2) Such reports must be on forms prescribed by the commission and must include:
(a) 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 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.
(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount medical plan organization, including any possible conflicts of interest.
(c) The number of discount medical plan members in the state.
(d) Such other information relating to the performance of the discount medical plan organization as is reasonably required by the commission or office.
(3) Every discount medical plan organization which fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first

10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

636.220 Minimum capital requirements.—
(1) Each discount medical plan organization must at all times maintain a net worth of at least $150,000.
(2) The office may not issue a license unless the discount medical plan organization has a net worth of at least $150,000.

636.226 Provider name listing.—Each discount medical plan organization must maintain an up-to-date list of the names and addresses of the providers with which it has contracted, on an Internet website page, the address of which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted.

636.228 Marketing of discount medical plans.—
(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing for such use by the discount medical plan organization.
(2) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan. Such agreement shall prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount medical plan organization. The discount medical plan organization shall be bound by any acts of its marketers, within the scope of the marketers' agency, that do not comply with the provisions of this part.

636.234 Service of process on a discount medical plan organization.—Sections 624.422 and 624.423 apply to a discount medical plan organization as if the discount medical plan organization were an insurer.

636.236 Surety bond or security deposit.—
(1) Each discount medical plan organization licensed pursuant to the provisions of this part must maintain in force 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 interests of members who may be adversely affected by the insolvency of a discount medical plan organization. The bond must be issued by an insurance company that is licensed to do business in this state.
(2) In lieu of the bond specified in subsection (1), a licensed discount medical plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount medical plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such deposited securities shall be returned to the discount medical plan organization no later than 45 days following the effective date of the surety bond.

(3) No judgment creditor or other claimant of a discount medical plan organization, other than the office or department, shall have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.481 Requirements for certain annuity agreements.—
(1) Any duly organized domestic or foreign nonstock corporation, or any unincorporated charitable trust, if such corporation or trust:
(a) Has been in active operation for at least 5 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,

may enter into annuity agreements with donors in accordance with this section. Such corporation or trust may receive gifts conditioned upon, or in return for, its agreement to pay an annuity to the donor or other designated beneficiary or beneficiaries and to make and carry out such annuity agreement. Annuity benefits under any such annuity agreement must be calculated to return to such corporation or trust upon the death of the annuitant a residue at least equal to one-half the original gift or other consideration for such annuity.

(2)(a) Every such domestic corporation or such domestic or foreign trust shall have and maintain admitted assets at least equal to the sum of the reserves on its outstanding annuity agreements, and a surplus of 10 percent of such reserves, calculated using:
1.a. The present value of future guaranteed benefits for individual annuities that have either commenced paying benefits or have fixed a future date of the first benefit payment.
b. The commissioner's annuity reserve method, as set forth in s. 625.121(7)(c), for individual deferred annuities that have not fixed a date for the first benefit payment.
2. The mortality tables used to value individual annuities, as defined in s. 625.121(5).
a. For annuities issued prior to July 1, 1998:
(I) The mortality tables described in s. 625.121(5)(h), for individual annuities;
(II) At the option of the corporation or trust, the 1983 Individual Annuity Mortality Table; or
(III) At the option of the corporation or trust, the 2000 Individual Annuity Mortality Table for annuities issued between January 1, 1998, and June 30, 1998, inclusive.
b. For annuities issued on or after July 1, 1998:

(I) The mortality tables set forth in s. 625.121(5)(i)3.;
(II) Any other mortality tables required to be used by insurers in accordance with s. 625.121; or
(III) At the option of the corporation or trust, any other mortality tables authorized to be used by insurers in accordance with s. 625.121.
3. An interest rate not greater than the maximum interest rate permitted for the valuation of individual annuities issued during the same calendar year as the charitable gift annuity for individual annuities as set forth in s. 625.121(6)(b)-(f).
a. The maximum statutory valuation interest rates for single-premium immediate annuities for 1992 may be used for annuities issued in 1992 or any prior year. The maximum statutory valuation interest rates for single-premium immediate annuities issued in 1992 through 2001 are as follows:

| Year of Issue | Single Premium Immediate Annuity Interest Rate |
|---|---|
| 1992 | 7.75 percent |
| 1993 | 7.00 percent |
| 1994 | 6.50 percent |
| 1995 | 7.25 percent |
| 1996 | 6.75 percent |
| 1997 | 6.75 percent |
| 1998 | 6.25 percent |
| 1999 | 6.25 percent |
| 2000 | 7.00 percent |
| 2001 | 6.75 percent |

b. For 2002 and subsequent years, until an interest rate for a specified year can be determined in accordance with s. 625.121(6), the prior year's rate shall be used unless the office requires use of a lower rate.
(b) In determining the reserves of any such corporation or trust, a deduction shall be made for all or any portion of an annuity risk which is reinsured by a life insurance company authorized to do business in this state.
(c)1. The assets of such corporation or trust in an amount at least equal to the sum of such reserves and surplus shall be invested only in mutual funds or investments permitted under part II of chapter 625 for the investment of the reserves of authorized life insurance companies.
2. For purposes of this section, the provisions of s. 625.305(2)(a) shall not apply. In lieu thereof, the fair market value of investments made by such corporation or trust in stock authorized by s. 625.324 may not exceed 50 percent of such corporation's or trust's required reserves and surplus. The fair market value in stock of any one corporation or mutual fund may not exceed 10 percent of such corporation's or trust's required reserves and surplus. All other provisions of s. 625.305 shall apply. Such assets shall be segregated as separate and distinct funds, independent of all other funds of such corporation or trust, and shall not be applied for the payment of the debts and obligations of the corporation or trust or for any purpose other than the annuity benefits specified in this section.
(3) No such foreign corporation shall make these annuity agreements in this state unless it complies with all the requirements of this section imposed upon like domestic corporations, except that the corporation may invest its reserve and surplus funds in the kind of securities permitted by the laws of the state in which it was incorporated or organized.
(4) Any corporation or trust that engages in the business of issuing these annuity agreements shall notify the office in writing by the later of 90 days after the effective date

of this act or the date on which it enters into the first of these annuity agreements. The notice must:
(a) Be signed by two or more officers or directors of the organization;
(b) Identify the organization; and
(c) Certify that the organization meets the requirements of this section.
(5) Any annuity agreement entered into by a corporation or trust must contain the following 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."
(6) If the office finds that any such corporation or trust has failed to comply with the requirements of this section, it may order such corporation or trust to cease making any new annuity agreements until such requirements have been satisfied. The office may, in its discretion, require annual statements by such corporation or trust and may accept in lieu thereof a sworn statement by two or more of the principal officers thereof, in such form as will satisfy the office that the requirements of this section are being complied with.
(7) Except as provided in this section, every such corporation or trust shall be exempt from the provisions of this code in making annuity agreements issued under this section.
(8) Any annuity agreement entered into by a corporation or trust the sole purpose of which is to support a state institution of higher learning shall contain the following 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."

(9) Agreements in the form of a charitable remainder unitrust trust, charitable remainder annuity trust, charitable lead trust, pooled income fund or other similar charitable split interest trust arrangement (not including a charitable gift annuity), described in ss. 170(f)(2)(A) and (B), 664(d)(1) and (2), and 642(c)(5) of the Internal Revenue Code are exempt from the provisions of subsections (1), (2), (3), and (5).
(10) The provisions of part IX of chapter 626 apply to issuers of annuity agreements under this section.
(11) The commission shall adopt rules and forms for the filing of annual statements and agreements pertaining to donor annuity organizations.

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641.403 Rulemaking authority.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the

accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.501 Filing, license, appointment, and miscellaneous fees.—

(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00

641.402 Definitions.—As used in this part, the term:
(1) "Basic services" includes any of the following: emergency care, physician care other than hospital inpatient physician services, ambulatory diagnostic treatment, and preventive health care services.
(2) "Guaranteeing organization" means an organization that is domiciled in the United States; that has authorized service of process against it; and that has appointed the Chief Financial Officer as its agent for service of process in connection with any cause of action arising in this state, based upon any guarantee entered into under this part.
(3) "Insolvent" or "insolvency" means the inability of a prepaid health clinic to discharge its liabilities as they become due in the normal course of business.
(4) "Prepaid health clinic" means any organization authorized under this part which provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.
(5) "Prepaid health clinic contract" means any contract entered into by a prepaid health clinic with a subscriber or group of subscribers to provide any of the basic services in exchange for a prepaid per capita or prepaid aggregate fixed sum.
(6) "Provider" means any physician or person other than a hospital that furnishes health care services and is licensed or authorized to practice in this state.
(7) "Reporting period" means the particular span of time by or for which accounts are redeemed on an annualized basis.
(8) "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a prepaid health clinic for health care services.
(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus includes capital stock, capital in excess of par, and retained earnings and may include surplus notes.
(10) "Surplus notes" means debt that has been guaranteed by the United States Government or its agencies or debt that has been subordinated to all claims of subscribers and general creditors of the prepaid health clinic.

641.405 Application for certificate of authority to operate prepaid health clinic.—
(1) No person may operate a prepaid health clinic without first obtaining a certificate of authority from the office. The office shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Agency for Health Care Administration.
(2) Each application for a certificate of authority shall be on such form as the commission prescribes, and such application shall be accompanied by:
(a) A copy of the basic organizational document of the applicant, if any, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable document, and all amendments to such document.
(b) A copy of the constitution, bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant.
(c) A list of the names, addresses, and official capacities with the applicant of the persons who are to be responsible for the conduct of the affairs of the clinic, including all members of the governing body, the officers and directors in the case of a corporation, and the partners or associates in the case of a partnership or association. Such persons shall fully disclose to the office and the governing body of the clinic the extent and nature of any contracts or arrangements between them and the clinic, including any possible conflicts of interest.
(d) A statement generally describing the clinic and its operations.
(e) Each form of prepaid health clinic contract that the applicant proposes to offer the subscribers, showing for each form of contract the benefits to which the subscribers are entitled, together with a table of the rates charged, or proposed to be charged.
(f) A copy of the applicant's Health Care Provider Certificate from the Agency for Health Care Administration, issued pursuant to part III of this chapter.
(g) A financial statement prepared on the basis of generally accepted accounting principles, except that surplus notes acceptable to the office may be included in the calculation of surplus.

641.41 Annual report of prepaid health clinic; administrative penalty.—
(1) Each prepaid health clinic shall file a report with the office, annually on or before March 1, or within 3 months of the end of the reporting period of the clinic, or within such extension of time for the filing of the report as the office, for good cause, may grant. The report of the prepaid health clinic must be filed on forms prescribed by the commission and must be verified under oath by two executive officers of the clinic or, if the clinic is not a corporation, verified under oath by two persons who are principal managing directors of the affairs of the clinic. The report of the clinic shall show the condition of the clinic on the last day of the immediately preceding reporting period. Such report shall include:
(a) A financial statement of the clinic, including its balance sheet and a statement of operations for the preceding year;
(b) A list of the name and residence address of every person responsible for the conduct of the affairs of the clinic, together with a disclosure of the extent and nature of any contract or arrangement between such person and the clinic, including any possible conflicts of interest;
(c) The number of prepaid health clinic contracts issued and outstanding, and the number of prepaid health clinic contracts terminated and a compilation of the reasons for such terminations;
(d) Such statistical information as is requested by the commission or office, which information shows the rates of the clinic for all basic services provided under prepaid health clinic contracts;
(e) The number and amount of damage claims for medical injury initiated against the clinic and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim; and

(f) Such other information relating to the performance of the clinic as is required by the commission or office.
(2) Any clinic which neglects to file the annual report in the form and within the time required by this section is subject to an administrative penalty, not to exceed $100 for each day during which the neglect continues; and, upon notice by the office to that effect, the authority of the clinic to do business in this state shall cease while such default continues.

641.416 Acquisition.—Every prepaid health clinic shall be subject to the provisions of s. 628.4615.

624.4431 Administration; rules.—The administration of ss. 624.436-624.446 is vested in the commission and office. The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of ss. 624.436-624.446.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee

member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a

report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.439 Filing of application.—The sponsoring association shall file with the office an application for a certificate of authority upon a form to be adopted by the commission and furnished by the office, signed under oath by officers of the trust, which shall include or have attached the following:
(1) A copy of the articles of incorporation, constitution, and bylaws of the association, if any.
(2) A list of the names, addresses, and official capacities within the arrangement of the individuals who are to be responsible for the management of and the conduct of the affairs of the arrangement, including all trustees, officers, and directors. Such individuals shall fully disclose to the office the extent and nature of any contracts or arrangements between themselves and the arrangement, including any possible conflicts of interest.
(3) A copy of the articles of incorporation, bylaws, or trust agreement which governs the operation of the arrangement.
(4) A copy of the policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided to covered employees, which shall be in accordance with s. 627.651(4), and which shall include a table of the rates charged, or proposed to be charged, for each form of such contract. A qualified actuary shall certify that:
(a) The rates are not inadequate.
(b) The rates are appropriate for the class of risks for which they have been computed.
(c) An adequate description of the rating methodology has been filed with the office and such methodology follows consistent and equitable actuarial principles.
(5) A copy of the fidelity bond in an amount equal to not less than 10 percent of the funds handled annually and 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. In no case may such bond be less than $50,000 or more than $500,000, except that the office, after due notice to all interested parties and opportunity for hearing, and after consideration of the record, may prescribe an amount in excess of $500,000, subject to the 10-percent limitation of the preceding sentence.
(6)(a) A copy of the arrangement's excess insurance agreement, which shall provide that the net retention level for any one risk shall not exceed $50,000, and which shall otherwise be in accordance with sound actuarial principles.
(b) The office may waive or modify the maximum net retention requirement if:
1. The excess insurance is not available for a reasonable cost; or
2. The arrangement:
a. Has 150 percent of the statutory reserve requirement as specified in s. 624.441;
b. Has a fund balance in excess of that required by statute; and
c. Has a ratio of current assets to current liabilities of at least 2.0 to 1.0.
(7)(a) A feasibility study, done by an independent qualified actuary and an independent certified public accountant, determined by the office to satisfactorily address market

potential, market penetration, market competition, operating expenses, gross revenues, net income, total assets and liabilities, cash flow, and such other items as the office or commission reasonably requires. The study shall 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 as required by s. 624.441 or have a fund balance less than the amount required by s. 624.4392.
(b) The feasibility study shall reflect and support that initial gross premiums for the first year of operation will be at least $100,000.
(8) Evidence satisfactory to the office showing that the arrangement will be operated in accordance with sound actuarial principles. The office shall not approve the arrangement unless the office determines that the plan is designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles.
(9) Confirmation of insolvency protection as required by s. 624.441.
(10) A copy of each contract between the arrangement and any administrator or service company which may be made available for review rather than filed or attached.
(11) Such additional information as the office or commission reasonably requires.

624.442 Annual reports; actuarial certification; quarterly reports; penalties.—
(1) Every arrangement shall, annually within 3 months after the end of the fiscal year or within such extension of time therefor as the office for good cause may grant, file a report with the office, on forms prescribed by the commission, verified by the oath of a member of the board of trustees and by an administrative executive appointed by the board, showing its condition on the last day of the preceding fiscal year. The report shall contain an audited financial statement of the arrangement prepared in accordance with statutory accounting principles, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant. The report shall also include an analysis of the adequacy of reserves and contributions or premiums charged, based on a review of past and projected claims and expenses.
(2) In addition to information called for and furnished in connection with the annual report, if reasonable grounds exist, the office may request information which summarizes paid and incurred expenses, and contributions or premiums received, and may request evidence satisfactory to the office that the arrangement is actuarially sound. Such information and evidence shall be furnished to the office by the arrangement as soon as reasonably possible after requested by the office, but not later than 30 days after such request, unless the office, for good cause, grants an extension.
(3) Annually, in conjunction with the annual report required by subsection (1), each arrangement shall submit an actuarial certification prepared by an independent actuary certifying that:
(a) The arrangement is actuarially sound. The certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of the obligations of, the arrangement.
(b) The rates being charged and to be charged for contracts are actuarially adequate through the end of the period for which rates have been guaranteed.
(c) Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.
(d) Such other information relating to the performance of the arrangement as the commission or office requires.
(4) Each arrangement shall file quarterly, within 45 days after the end of each of its four quarterly reporting periods, an unaudited financial statement of the arrangement on forms prescribed by the commission, verified according to the best of their information, knowledge, and belief by the oath of a member of the board of trustees and by an

administrative executive appointed by the board showing its condition on the last day of the preceding quarter.
(5) Any arrangement that fails to file an annual financial report, actuarial report, or quarterly financial report in the form and within the time required by this section shall forfeit to the office an amount set by order of the office which does not exceed $1,000 for each of the first 10 days of noncompliance and does not exceed $2,000 for each subsequent day of noncompliance. Upon notice by the office that the arrangement is not in compliance with this section, the arrangement's authority to enroll new enrollees or to do business in this state ceases until the office determines the arrangement to be in compliance. The office may not collect more than $100,000 under this subsection with respect to any particular report.
(6) All moneys collected by the office under this section shall be deposited to the credit of the Insurance Regulatory Trust Fund.
(7) Each authorized arrangement must retain an independent certified public accountant, referred to in this subsection as "CPA," who agrees by written contract with the arrangement to comply with ss. 624.436-624.445. The contract must state that:
(a) The CPA will provide to the arrangement audited financial statements consistent with ss. 624.436-624.445.
(b) Any determination by the CPA that the arrangement does not meet the minimum surplus requirements set forth in ss. 624.436-624.445 will be stated by the CPA, in writing, in the audited financial statement.
(c) The completed workpapers and any written communications between the CPA and the arrangement will be made available for review on a visual inspection-only basis by the office at the location of the arrangement, the office, or any other reasonable place agreeable to both the office and the arrangement.
(d) The CPA will retain for review the workpapers and written communications with the arrangement for not less than 6 years.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of

the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;

(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and

(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.

(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.

(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:

(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,

2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:

a. Each director, officer, or trustee, if a corporation, or

b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(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.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal [1]Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law 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, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:
1. To liquidate the specialty insurer, sell 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, or
2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.

(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;

7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or
9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.
(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.
(d) For the purpose of this section, the term "natural person" means an individual.
(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.
(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively

641.31 Health maintenance contracts.—
(1) Any entity issued a certificate and otherwise in compliance with this part may enter into contracts in this state to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum. Each subscriber shall be given a copy of the applicable health maintenance contract, certificate, or member handbook. Whichever document is provided to a subscriber shall contain all of the provisions and disclosures required by this section.
(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.
(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the office the proposed change or amendment. Any proposed change shall be effective immediately, subject to disapproval by the office. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or use any form disapproved by the office or as to which the office has withdrawn approval.
(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group.
(c) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:
1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.
2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. Has any title, heading, or other indication of its provisions which is misleading.
4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.
5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.
6. Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune

deficiency syndrome which are different than those which apply to any other sickness or medical condition.
(d) Any change in rates charged for the contract must be filed with the office not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the office. The approval of the filing by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved. This paragraph does not apply to group health contracts effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(e) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.
(4) Every health maintenance contract, certificate, or member handbook shall clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the health maintenance organization. The contract, certificate, or member handbook shall also state where and in what manner the comprehensive health care services may be obtained.
(5) Every subscriber shall receive a clear and understandable description of the method of the health maintenance organization for resolving subscriber grievances, and the method shall be set forth in the contract, certificate, and member handbook. The organization shall also furnish, at the time of initial enrollment and when necessary due to substantial changes to the grievance process a separate and additional communication prepared or approved by the office notifying the contract holder of a group contract or subscriber of an individual contract of their rights and responsibilities under the grievance process.
(6) The rate of payment for a health maintenance contract shall be a part of the contract and shall be stated in individual contracts issued to subscribers.
(7) A health maintenance organization is entitled to coordinate benefits on the same basis as an insurer under s. 627.4235.
(8) A health maintenance organization providing medical benefits or payments to a subscriber who suffers injury, disease, or illness by virtue of the negligent act or omission of a third party is entitled to reimbursement from the subscriber in accordance with s. 768.76(4).
(9) All health maintenance contracts that provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children must be provided with respect to a newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth. However, with respect to a newborn child of a covered family member other than the spouse of the insured or subscriber, the coverage for the newborn child terminates 18 months after the birth of the newborn child. The coverage, benefits, or services for newborn children must consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the

attending physician as medically necessary to protect the health and safety of the newborn child.
(a) A contract may require the subscriber to notify the plan of the birth of a child within a time period, as specified in the contract, of not less than 30 days after the birth, or a contract may require the preenrollment of a newborn prior to birth. However, if timely notice is given, a plan may not charge an additional premium for additional coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not given, the plan may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure of the subscriber to timely notify the plan of the birth of the child or to preenroll the child.
(b) If the contract does not require the subscriber to notify the plan of the birth of a child within a specified time period, the plan may not deny coverage of the child nor may it retroactively charge the subscriber an additional premium for the child; however, the contract may prospectively charge the member an additional premium for the child if the plan provides at least 45 days' notice of the additional charge.
(10) No alteration of any written application for any health maintenance contract shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the health maintenance organization, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.
(11) No contract shall contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to health maintenance organizations.
(12) Each health maintenance contract, certificate, or member handbook shall state that emergency services and care shall be provided to subscribers in emergency situations not permitting treatment through the health maintenance organization's providers, without prior notification to and approval of the organization. Not less than 75 percent of the reasonable charges for covered services and supplies shall be paid by the organization, up to the subscriber contract benefit limits. Payment also may be subject to additional applicable copayment provisions, not to exceed $100 per claim. The health maintenance contract, certificate, or member handbook shall contain the definitions of "emergency services and care" and "emergency medical condition" as specified in s. 641.19(6) and (7), shall describe procedures for determination by the health maintenance organization of whether the services qualify for reimbursement as emergency services and care, and shall contain specific examples of what does constitute an emergency. In providing for emergency services and care as a covered service, a health maintenance organization shall be governed by s. 641.513.
(13) In addition to the requirements of this section, with respect to a person who is entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), parts A and/or B:
(a) The health maintenance organization shall mail or deliver notification to the Medicare beneficiary of the date of enrollment in the health maintenance organization within 10 days after receiving notification of enrollment approval from the United States Department of Health and Human Services, Health Care Financing Administration. When a Medicare beneficiary who is a subscriber of the health maintenance organization requests disenrollment from the organization, the organization shall mail or deliver to the beneficiary notice of the effective date of the disenrollment within 10 days after receipt of the written disenrollment request. The health maintenance organization shall forward the disenrollment request to the United States Department of Health and Human Services, Health Care Financing Administration, in a timely manner so as to effectuate the next available disenrollment date, as prescribed by such federal agency.

(b) The health maintenance contract, certificate, or member handbook shall be delivered to the subscriber no later than the earlier of 10 working days after the health maintenance organization and the Health Care Financing Administration of the United States Department of Health and Human Services approve the subscriber's enrollment application or the effective date of coverage of the subscriber under the health maintenance contract. However, if notice from the Health Care Financing Administration of its approval of the subscriber's enrollment application is received by the health maintenance organization after the effective coverage date prescribed by the Health Care Financing Administration, the health maintenance organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving such notice. When a Medicare recipient is enrolled in a health maintenance organization program, the contract, certificate, or member handbook shall be accompanied by a health maintenance organization identification sticker with instruction to the Medicare beneficiary to place the sticker on the Medicare identification card.

(14) Whenever a subscriber of a health maintenance organization is also a Medicaid recipient, the health maintenance organization's coverage shall be primary to the recipient's Medicaid benefits and the organization shall be a third party subject to the provisions of s. 409.910(4).

(15)(a) All health maintenance contracts, certificates, and member handbooks shall contain the following provision:

"Grace Period: This contract has a (insert a number not less than 10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the contract will stay in force."

(b) The required provision of paragraph (a) shall not apply to certificates or member handbooks delivered to individual subscribers under a group health maintenance contract when the employer or other person who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscribers. However, such required provision shall apply to the group health maintenance contract.

(16) The contracts must clearly disclose the intent of the health maintenance organization as to the applicability or nonapplicability of coverage to preexisting conditions. If coverage of the contract is not to be applicable to preexisting conditions, the contract shall specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sicknesses are limited to those which first manifest themselves subsequent to the effective date of coverage.

(17) All health maintenance contracts that provide coverage for a member of the family of the subscriber, shall, as to such family member's coverage, provide that coverage, benefits, or services applicable for children shall be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement in the residence of the subscriber. Such contracts may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage shall begin from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child, whether or not such agreement is enforceable. However, coverage for such child shall not be required in the event that the child is not ultimately placed in the residence of the subscriber in compliance with chapter 63.

(18)(a) Health maintenance contracts that provide coverage, benefits, or services for maternity care must provide, as an option to the subscriber, the services of nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed pursuant to ss. 383.30-383.335, if such services are available within the service area.

(b) Any health maintenance contract that provides maternity or newborn coverage may not limit coverage for the length of a maternity or newborn stay in a hospital or for followup

care outside of a hospital to any time period that is less than that determined to be medically necessary, in accordance with prevailing medical standards and consistent with guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists, by the treating obstetrical care provider or the pediatric care provider.

(c) This section does not affect any agreement between a health maintenance organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and this section does not prohibit appropriate utilization review or case management by a health maintenance organization.

(d) Any health maintenance contract that provides coverage, benefits, or services for maternity or newborn care must provide coverage for postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

(e) A health maintenance organization subject to paragraph (b) shall communicate active case questions and concerns regarding postdelivery care directly to the treating physician or hospital in written form, in addition to other forms of communication. Such organization shall also use a process that includes a written protocol for utilization review and quality assurance.

(f) Any health maintenance organization subject to paragraph (b) may not:

1. Deny to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this section.
2. Provide monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under this section.
3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an individual participant or beneficiary in accordance with this section.
4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.
5. Subject to paragraph (i), restrict benefits for any portion of a period within a hospital length of stay required under paragraph (b) in a manner that is less favorable than the benefits provided for any preceding portion of such stay.

(g) This subsection does not require a mother who is a participant or beneficiary to:

1. Give birth in a hospital.
2. Stay in the hospital for a fixed period of time following the birth of her infant.

(h) This subsection does not apply with respect to any coverage offered by a health maintenance organization that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant.

(i) This subsection does not prevent a health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant under the contract or under health insurance coverage offered in connection with a group health plan, except that such coinsurance or other cost sharing for any portion of a period within a hospital length of stay required under paragraph (b) may not be greater than such coinsurance or cost sharing for any preceding portion of such stay.

(19) Notwithstanding any other provision of law, health maintenance policies or contracts which provide coverage, benefits, or services as described in s. 463.002(7), shall offer to the subscriber the services of an optometrist licensed pursuant to chapter 463.
(20) Notwithstanding any other provision of law, health maintenance policies or contracts which provide coverage, benefits, or services which are performed by physicians who are ophthalmologists, licensed pursuant to chapter 458 or chapter 459, shall offer the subscriber the services of an ophthalmologist. For purposes of this subsection, ophthalmologists are physicians specializing in the diagnosis and treatment of diseases and injuries of the eye.
(21) Notwithstanding any other provision of law, health maintenance policies or contracts which provide anesthesia coverage, benefits, or services shall offer to the subscriber, if requested and available, the services of a certified registered nurse anesthetist licensed pursuant to part I of chapter 464.
(22) Each health maintenance organization that offers a group plan within this state must have at least one open enrollment period of not less than 30 days every 18 months. Such open enrollment periods are required for as long as the group exists unless the health maintenance organization and the employer mutually agree to a shorter period of time than 18 months.
(23) The contract shall include the following provision:

"Time limit on certain defenses: Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period."

(24) Each health maintenance organization that provides for inpatient and outpatient services by allopathic hospitals shall provide as an option of the subscriber similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available in the same service area of the HMO and the osteopathic hospital agrees to provide the services as specified herein. As a condition precedent to providing osteopathic inpatient and outpatient services through an osteopathic hospital that has not entered into a written contract with the HMO, the HMO may require the subscriber or any other person receiving osteopathic services to release the HMO from any liability arising from any act of omission or commission constituting malpractice in the delivery of osteopathic care from that hospital. The osteopathic hospital providing the inpatient and outpatient services for the HMO shall charge rates that do not exceed the osteopathic hospital's usual and customary rates less the average discount provided by allopathic hospitals providing the HMO services in the same service area of the HMO.
(25) If a subscriber is a resident of a continuing care facility certified under chapter 651 or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the subscriber's primary care physician must refer the subscriber to that facility's skilled nursing unit or assisted living facility if requested by the subscriber and agreed to by the facility; if the primary care physician finds that such care is medically necessary; if the facility agrees to be reimbursed at the health maintenance organization's contract rate negotiated with similar providers for the same services and supplies; and if the facility meets all guidelines established by the health maintenance organization related to quality of care, utilization, referral authorization, risk assumption, use of the health maintenance organization's network, and other criteria applicable to providers under contract for the same services and supplies. If a health maintenance organization enrolls a new subscriber who already resides in a continuing care facility or a retirement facility as described in this subsection, the health maintenance organization must provide in writing a disclosure of the subscriber's rights under this subsection. If a subscriber's request to be referred to the skilled nursing unit or assisted living facility that is part of the subscriber's

place of residence is not honored, the subscriber may use the grievance process provided in s. 641.511.
(26)(a) Each health maintenance organization and prepaid health plan shall provide coverage for all medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if the patient's primary care physician, or the physician to whom the patient has been referred who specializes in treating diabetes, certifies that the equipment, supplies, or services are necessary.
(b) The contract may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist under contract with or designated by the health maintenance organization or prepaid health plan.
(c) The Agency for Health Care Administration shall adopt standards for outpatient self-management training and educational services, taking into consideration standards approved by the American Diabetes Association.
(27) Any health maintenance contract that covers a resident of this state and that is issued, amended, delivered, or renewed in this state after October 1, 1996, must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis. This subsection shall not apply to the state employee health insurance program.
(28) A health maintenance organization may not discriminate against or fail to contract with a hospital, based solely on the fact that the hospital's medical staff is comprised of physicians licensed under chapter 459. Nothing in this subsection shall mandate that a health maintenance organization contract with a hospital.
(29) If a health maintenance contract provides that coverage of a dependent child of the subscriber terminates upon attainment of the limiting age for dependent children which is specified in the contract, the contract must also provide in substance that attainment of the limiting age does not terminate the coverage of the child while the child continues to be both:
(a) Incapable of self-sustaining employment by reason of an intellectual or physical disability.
(b) Chiefly dependent upon the employee or member for support and maintenance.

If the claim is denied under a contract for the stated reason that the child has attained the limiting age for dependent children specified in the contract, the notice or denial must state that the subscriber has the burden of establishing that the child continues to meet the criteria specified in this subsection.

(30)(a) All health maintenance contracts which provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, also provide that the benefits applicable for children include coverage for child health supervision services from the moment of birth to age 16 years.
(b) As used in this subsection, the term "child health supervision services" means physician-delivered or physician-supervised services that include, at a minimum, services delivered at the intervals and scope stated in this subsection.
1. Child health supervision services must include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

2. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this subsection.
(31)(a) Health maintenance contracts that provide coverage, benefits, or services for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician under contract with the health maintenance organization to be medically necessary in accordance with prevailing medical standards and after consultation with the covered patient. Such contract must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional under contract with the health maintenance organization qualified to provide postsurgical mastectomy care. The treating physician under contract with the health maintenance organization, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the covered patient.
(b) A health maintenance organization subject to this subsection may not:
1. Deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this subsection;
2. Provide monetary payments or rebates to a covered patient to accept less than the minimum protections available under this subsection;
3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to a covered patient under this subsection;
4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to a covered patient in a manner inconsistent with this subsection; or
5. Subject to the other provisions of this subsection, restrict benefits for any portion of a period within a hospital length of stay or outpatient care as required by this subsection in a manner that is less than favorable than the benefits provided for any preceding portion of such stay.
(c)1. This subsection does not require a covered patient to have the mastectomy in the hospital or stay in the hospital for a fixed period of time following the mastectomy.
2. This subsection does not prevent a contract from imposing deductibles, coinsurance, or other cost sharing in relation to benefits pursuant to this subsection, except that such cost sharing shall not exceed cost sharing with other benefits.
(d) Except as provided in paragraph (b), this subsection does not affect any agreement between a health maintenance organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and does not prohibit appropriate utilization review or case management by the health maintenance organization.
(e) As used in this subsection, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.
(32) A health maintenance contract that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. As used in this subsection, the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts. Such surgery must be in a manner chosen by the treating physician under contract with the health maintenance organization, consistent with prevailing medical standards, and in consultation with the patient. The health maintenance organization may charge an appropriate additional premium for the coverage required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery shall be subject to any deductible and coinsurance conditions.
(33) Notwithstanding any provision of this section to the contrary, a health maintenance organization which offers dermatological services shall provide direct patient access, for

office visits and minor procedures and testing, to a dermatologist who is under contract with the health maintenance organization. The term "direct patient access" means the ability of a subscriber to obtain such services without a referral or other authorization before receiving services. The health maintenance organization shall, by July 1, 1997, develop criteria for compliance with the provisions of this subsection which do not impede or inhibit access to dermatological services for policyholders of the health maintenance organization. The criteria may include a maximum of five office visits to a dermatologist without prior authorization for a dermatologic problem within a 12-month period.

(34) For purposes of this subsection, dental treatment or surgery shall be considered necessary when the dental condition is likely to result in a medical condition if left untreated. Any health maintenance organization contract which provides coverage for general anesthesia and hospitalization services to a covered person shall not preclude such coverage in assuring the safe delivery of necessary dental care provided to a covered person who:

(a) Is under 8 years of age and is determined by a licensed dentist, and the child's physician licensed under chapter 458 or chapter 459, to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

(b) Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

As provided herein, all terms and conditions of the covered person's health maintenance organization contract shall apply to such services, and this section does not require coverage for the diagnosis or treatment of dental disease. A health maintenance organization may require prior authorization for general anesthesia and hospital services required under this section in the same manner the organization requires prior authorization for hospitalization for other covered services. This subsection shall not apply to Medicare supplement, long-term care, disability, limited benefit, accident only, or specified disease policies.

(35) A health maintenance contract that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child. The coverage must include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the primary care physician or physician to whom the child is referred and such physician certifies that such services are medically necessary and consequent to treatment of the cleft lip or cleft palate. The coverage required by this section is subject to terms and conditions applicable to other benefits.

(36) A health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The health maintenance organization may amend the contract with the contract holder, with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder shall specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period which will be included in the group contract upon renewal. This subsection does not apply to any increases in benefits. The 45-day notice requirement shall not apply if benefits are amended, deleted, or limited at the request of the contract holder.

(37) All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 as medically necessary and the prescription specifies the number of

treatments. Such massage services are subject to the same terms, conditions, and limitations as those of other covered services.
(38)(a) Notwithstanding any other provision of this part, a health maintenance organization that meets the requirements of paragraph (b) may, through a point-of-service rider to its contract providing comprehensive health care services, include a point-of-service benefit. Under such a rider, a subscriber or other covered person of the health maintenance organization may choose, at the time of covered service, a provider with whom the health maintenance organization does not have a health maintenance organization provider contract. The rider may not require a referral from the health maintenance organization for the point-of-service benefits.
(b) A health maintenance organization offering a point-of-service rider under this subsection must have a valid certificate of authority issued under the provisions of the chapter, must have been licensed under this chapter for a minimum of 3 years, and must at all times that it has riders in effect maintain a minimum surplus of $5 million. A health maintenance organization offering a point-of-service rider to its contract providing comprehensive health care services may offer the rider to employers who have employees living and working outside the health maintenance organization's approved geographic service area without having to obtain a health care provider certificate, as long as the master group contract is issued to an employer that maintains its primary place of business within the health maintenance organization's approved service area. Any member or subscriber that lives and works outside the health maintenance organization's service area and elects coverage under the health maintenance organization's point-of-service rider must provide a statement to the health maintenance organization that indicates the member or subscriber understands the limitations of his or her policy and that only those benefits under the point-of-service rider will be covered when services are provided outside the service area.
(c) Premiums paid in for the point-of-service riders may not exceed 15 percent of total premiums for all health plan products sold by the health maintenance organization offering the rider. If the premiums paid for point-of-service riders exceed 15 percent, the health maintenance organization must notify the office and, once this fact is known, must immediately cease offering such a rider until it is in compliance with the rider premium cap.
(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.3154 does not apply to a point-of-service rider authorized under this subsection.
(e) The point-of-service rider must contain provisions that comply with s. 627.6044.
(f) The term "point of service" may not be used by a health maintenance organization except with riders permitted under this section or with forms approved by the office in which a point-of-service product is offered with an indemnity carrier.
(g) A point-of-service rider must be filed and approved under ss. 627.410 and 627.411.
(39) A health maintenance organization contract may not prohibit or restrict a subscriber from receiving inpatient services in a contracted hospital from a contracted primary care or admitting physician if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.
(40)(a) Any group rate, rating schedule, or rating manual for a health maintenance organization policy, which provides creditable coverage as defined in s. 627.6562(3), filed

with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. The group must provide evidence of demonstrative maintenance or improvement of his or her health status as determined by assessments of agreed-upon health status indicators between the group and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may not exceed 10 percent of paid premiums.

(b) The premium rebate authorized by this section shall be effective for a subscriber on an annual basis, unless the number of participating members on the contract renewal anniversary becomes fewer than the majority of the members eligible for participation in the wellness program.

(c) A health maintenance organization that issues individual contracts may offer a premium rebate, as provided under this section, for a healthy lifestyle program.

(41) All health maintenance contracts providing coverage for a member of the subscriber's family must comply with the provisions of s. 627.6562.

(42) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization offering the contract or name of the organization administering the contract, whichever applies.

(b) The name of the subscriber.

(c) A statement that the health plan is a health maintenance organization. Only a health plan with a certificate of authority issued under this chapter may be identified as a health maintenance organization.

(d) The member identification number, contract number, and group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the contract may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

(43) Whenever, in any health maintenance organization claim form, a subscriber specifically authorizes payment of benefits directly to any contracted hospital, ambulance provider, physician, or dentist, the health maintenance organization shall make such payment to the designated provider of such services if any benefits are due to the subscriber under the terms of the agreement between the subscriber and the health maintenance organization. The health maintenance organization contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, ambulance provider, physician, or dentist for covered services provided, for services provided pursuant to s. 395.1041, and for ambulance transport and treatment

provided pursuant to part III of chapter 401. The attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the health maintenance organization may not be more than the amount that the insurer would otherwise have paid without the assignment. This subsection does not affect the applicability of ss. 641.3154 and 641.513 with respect to services provided and payment for such services provided pursuant to the subsection.

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:
(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The

notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.
(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.
(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:
(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,
2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:
a. Each director, officer, or trustee, if a corporation, or
b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(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.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal [1]Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law 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, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public

health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the specialty insurer, sell 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, or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation,

without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.

(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.

(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.

(13)(a) For the purpose of this section, the term "acquisition" includes:

1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:

1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;
7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or
9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.

(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the

voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.
(d) For the purpose of this section, the term "natural person" means an individual.
(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.
(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

627.410 Filing, approval of forms.—

(6)(a) An insurer may not deliver, issue for delivery, or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof, as specified in such rule, to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 are for informational purposes.
(c) Every filing made pursuant to this subsection shall be made within the same time period, and shall be deemed to be approved under the same conditions, as provided in subsection (2).
(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, is prohibited from applying the following rating practices:
1. Select and ultimate premium schedules.
2. Premium class definitions that classify insured based on year of issue or duration since issue.
3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.
(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form is not considered to be available for purchase unless the insurer has actively offered it for sale during the previous 12 months.
1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing at least 30 days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may no longer offer the policy form or certificate form for sale in this state.
2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may not file for approval a new policy form providing benefits similar to the discontinued form for 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is

appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form because it does not comply with PPACA.
3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that the experience of grandfathered health plans and nongrandfathered health plans shall be separated.
(7) Each insurer subject to subsection (6) shall make an annual filing with the office within 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.
(a) The filing shall be satisfied by one of the following methods:
1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted by the commission.
2. If no rate change is proposed, a filing that consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.
(b) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.
(c) If at the time a filing is required an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by the date the filing is due.
(d) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

627.413 Contents of policies, in general; identification

(4) All policies and annuity contracts issued by insurers, and the forms thereof filed with the office, shall have printed thereon an appropriate designating letter or figure, or combination of letters or figures or terms identifying the respective forms of policies or contracts. Whenever any change is made in any such form, the designating letters, figures, or terms thereon shall be correspondingly changed.

627.4145 Readable language in insurance policies.—
(1) Every policy shall be readable as required by this section. For the purposes of this section, the term "policy" means a policy form or endorsement. A policy is deemed readable if:
(a) The text achieves a minimum score of 45 on the Flesch reading ease test as computed in subsection (5) or an equivalent score on any other test comparable in result and approved by the office;
(b) It uses layout and spacing which separate the paragraphs from each other and from the border of the paper;

(c) It has section titles that are captioned in boldfaced type or that otherwise stand out significantly from the text;
(d) It avoids the use of unnecessarily long, complicated, or obscure words, sentences, paragraphs, or constructions;
(e) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and
(f) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words or more than three pages.
(2) The office may authorize a lower score than the Flesch reading ease test score required in subsection (1) whenever it finds that a lower score will provide a more accurate reflection of the readability of a policy form, is warranted by the nature of a particular policy form or type or class of policy forms, or is the result of language which is used to conform to the requirements of any law.
(3) A filing subject to this section shall be accompanied by a certification signed by an officer of the insurer stating that the policy meets the requirements of subsection (1). Such certification shall state that the policy meets the minimum reading ease test score on the test used or that the score is lower than the minimum required but should be approved in accordance with subsection (2). The office may require the submission of further information to verify any certification.
(4) Any non-English language policy shall be deemed to be in compliance with this section if the insurer certifies that such policy is translated from an English language policy which complies with this section.
(5) A Flesch reading ease test score shall be measured by the following method:
(a) For policy forms containing 10,000 words or fewer of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, the readability of two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.
(b) The total number of words in the text shall be counted and divided by the total number of sentences, and the figure obtained shall be multiplied by a factor of 1.015.
(c) The total number of syllables shall be counted and divided by the total number of words, and the figure obtained shall be multiplied by a factor of 84.6.
(d) The sum of the figures computed under paragraphs (b) and (c) subtracted from 206.835 equals the Flesch reading ease test score for the policy form.
(e) For purposes of this subsection:
1. A contraction, hyphenated word, or numerals and letters, when separated by spaces, shall be counted as one word; and
2. A unit of words ending with a period, semicolon, or colon, excluding headings and captions, shall be counted as one sentence.
(f) The term "text" as used in this subsection includes all printed matter except:
1. The name and address of the insurer; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; specification pages; schedules; or tables;
2. Policy language required by any collectively bargained agreement;
3. Any medical terminology;
4. Words which are defined in the policy; and
5. Any policy language required by law, if the insurer identifies the language or terminology excepted by this paragraph and certifies to the office, in writing, that the language or terminology is entitled to be excepted under this paragraph.
(g) At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they are to be used.
(6) This section does not apply to:
(a) Any policy which is a security subject to federal jurisdiction;

(b) Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy; however, this paragraph does not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state;
(c) Any group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
(d) Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this section;
(e) Any policy or form, or partial revision thereof, or renewal thereof, which policy or form is filed prior to October 1, 1983; or
(f) Endorsements filed on or after October 1, 1983, which modify policy forms prior to October 1, 1983.
(g) Mortgage guaranty insurance policies, as defined in s. 635.011.
(7) This section applies to forms filed on or after October 1, 1983.

627.6699 Employee Health Care Access Act.—

(12) STANDARDS TO ASSURE FAIR MARKETING.—

(d) A small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

627.6735 Order to discontinue certain advertising.—An insurer must file with the office all advertisements for Medicare supplement policies pursuant to rules adopted by the commission. If, in the opinion of the office, any advertisement by a Medicare supplement policy insurer violates any of the provisions of part IX of chapter 626 or any rule of the commission, the office may enter an immediate order requiring that the use of the advertisement be discontinued. If requested by the insurer, the office shall conduct a hearing within 10 days of the entry of such order. If, after the hearing or by agreement with the insurer, a final determination is made that the advertising was in fact violative of any provision of part IX of chapter 626 or of any rule of the commission, the office may, in lieu of revocation of the certificate of authority, require the publication of a corrective advertisement; impose an administrative penalty of up to $10,000; and, in the case of an initial solicitation, require that the insurer, prior to accepting any application received in response to the advertisement, provide an acceptable clarification of the advertisement to each individual applicant.

627.682 Filing, approval of forms.—All forms of policies, certificates of insurance, statements of insurance, applications for insurance, binders, endorsements, and riders of credit life or disability insurance delivered or issued for delivery in this state shall be filed with and approved by the office before use as provided in ss. 627.410 and 627.411. In

addition to grounds as specified in s. 627.411, the office, upon compliance with the procedures set forth in s. 627.410, shall disapprove any such form and may withdraw any previous approval thereof if the benefits provided therein are not reasonable in relation to the premiums charged, or if it contains provisions which are unjust, unfair, inequitable, misleading, or deceptive or which encourage misrepresentation of such policy.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(2) ADVERTISING.—The commission shall adopt rules establishing standards for the advertising, marketing, and sale of long-term care insurance policies in order to protect applicants from unfair or deceptive sales or enrollment practices. An insurer shall file with the office any long-term care insurance advertising material intended for use in this state and may immediately begin using such material upon filing, subject to subsequent disapproval by the office. Following receipt of a notice of disapproval or a withdrawal of approval, the insurer must immediately cease use of the disapproved material. The office may also disapprove an advertisement at any time and enter an immediate order requiring that the use of the advertisement be discontinued if it determines that the advertisement violates this part, part IX of chapter 626, or any rule of the commission.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.
(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.
(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:
(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,
2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:
a. Each director, officer, or trustee, if a corporation, or
b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(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.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law 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, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10

days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the specialty insurer, sell 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, or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or

s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;
7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or

9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.
(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.
(d) For the purpose of this section, the term "natural person" means an individual.
(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.
(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

641.19 Definitions.—

(5) "Copayment" means a specific dollar amount, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services. Copayments may not be established in an amount that will prevent a person from receiving a covered service or benefit as specified in the subscriber contract approved by the office.

641.21 Application for certificate.—
(1) Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the office. The office shall accept and shall begin its review of an application for a certificate of authority anytime after an organization has filed an application for a health care provider certificate pursuant to part III of this chapter. However, the office may not issue a certificate of authority to any applicant which does not possess a valid health care provider certificate issued by the agency. Each application for a certificate shall be on such form as the commission shall prescribe, shall be verified by the oath of two officers of the corporation and properly notarized, and shall be accompanied by the following:
(a) A copy of the articles of incorporation and all amendments thereto;
(b) A copy of the bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant;
(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, directors, and owners of in excess of 5 percent of the common stock of the corporation. Such persons shall fully disclose to the office and the directors of the health maintenance organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest;
(d) A complete biographical statement on forms prescribed by the commission, and an independent investigation report and fingerprints obtained pursuant to chapter 624, of all of the individuals referred to in paragraph (c);
(e) A statement generally describing the health maintenance organization, its operations, and its grievance procedures;
(f) Forms of all health maintenance contracts, certificates, and member handbooks the applicant proposes to offer the subscribers, showing the benefits to which they are entitled,

together with a table of the rates charged, or proposed to be charged, for each form of such contract. A certified actuary shall:
1. Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
2. Certify that the rates are appropriate for the classes of risks for which they have been computed; and
3. File an adequate description of the rating methodology showing that such methodology follows consistent and equitable actuarial principles;
(g) A statement describing with reasonable certainty the geographic area or areas to be served by the health maintenance organization;
(h) As to any applicant whose business plan indicates that it will receive Medicaid funds, a list of 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 of authority, 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. The contract, agreement, and related information shall, if requested, be provided to the office.
(i) An audited financial statement prepared on the basis of statutory accounting principles and certified by an independent certified public accountant, except that surplus notes acceptable to the office and meeting the requirements of this act shall be included in the calculation of surplus; and
(j) Such additional reasonable data, financial statements, and other pertinent information as the commission or office requires with respect to the determination that the applicant can provide the services to be offered.

641.22 Issuance of certificate of authority

(2) The health maintenance organization is actuarially sound.

(4) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit experience rating.

(6) The ownership, control, and management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The office shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which the office has good reason to believe that:
(a) The ownership, control, or management of the organization includes any person:
1. Who is incompetent or untrustworthy;
2. Who is so lacking in health maintenance organization expertise as to make the operation of the health maintenance organization hazardous to potential and existing subscribers;
3. Who is so lacking in health maintenance organization experience, ability, and standing as to jeopardize the reasonable promise of successful operation;
4. Who is affiliated, directly or indirectly, through ownership, control, reinsurance transactions, or other business relations, with any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; or

5. Whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors;
(b) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the health maintenance organization, does not possess the financial standing and business experience for the successful operation of the health maintenance organization;
(c) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the health maintenance organization, has been found guilty of, or has pled guilty or no contest to, any felony or crime punishable by imprisonment of 1 year or more under the laws of the United States or any state thereof or under the laws of any other country, which involves moral turpitude, without regard to whether a judgment or conviction has been entered by the court having jurisdiction in such case. However, in the case of a health maintenance organization operating under a subsisting certificate of authority, the health maintenance organization shall remove any such person immediately upon discovery of the conditions set forth in this paragraph when applicable to such person or under the order of the office, and the failure to so act by the organization is grounds for revocation or suspension of the health maintenance organization's certificate of authority; or
(d) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the health maintenance organization, is now or was in the past affiliated, directly or indirectly, through ownership interest of 10 percent or more, control, or reinsurance transactions, with any business, corporation, or other entity that has been found guilty of or has pleaded guilty or nolo contendere to any felony or crime punishable by imprisonment for 1 year or more under the laws of the United States, any state, or any other country, regardless of adjudication. In the case of a health maintenance organization operating under a subsisting certificate of authority, the health maintenance organization shall immediately remove such person or immediately notify the office of such person upon discovery of the conditions set forth in this paragraph, either when applicable to such person or upon order of the office. The failure to remove such person, provide such notice, or comply with such order constitutes grounds for suspension or revocation of the health maintenance organization's certificate of authority.

(9) The health maintenance organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

641.221 Continued eligibility for certificate of authority.—In order to maintain its eligibility for a certificate of authority, a health maintenance organization shall continue to meet all conditions required to be met under this part and the rules promulgated thereunder for the initial application for and issuance of its certificate of authority under s. 641.22.

641.225 Surplus requirements.—
(1) Each health maintenance organization shall at all times maintain a minimum surplus in an amount that is the greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of total annualized premium.

(2) The office shall not issue a certificate of authority unless the health maintenance organization has a minimum surplus in an amount which is the greater of:
(a) Ten percent of their total liabilities based on their startup projection as set forth in this part;
(b) Two percent of their total projected premiums based on their startup projection as set forth in this part; or
(c) $1,500,000, plus all startup losses, excluding profits, projected to be incurred on their startup projection until the projection reflects statutory net profits for 12 consecutive months.
(3) The commission may adopt rules to set uniform standards and criteria for the early warning that the continued operation of any health maintenance organization might be hazardous to its subscribers, creditors, or the general public, and to set standards for evaluating the financial condition of any health maintenance organization.
(4) A surplus note shall not be used to initially capitalize a health maintenance organization.
(5) In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the health maintenance organization, provided that the written guarantee is made by a guaranteeing organization which:
(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of the greater of $2 million or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply, except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. If the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations.
(b) Submits a guarantee that is approved by the office as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless the guaranteeing organization can demonstrate to the office that the cancellation of the guarantee will not result in the insolvency of the health maintenance organization and the office approves cancellation of the guarantee.
(c) Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.
(d) Submits annually, within 3 months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles. The office may, as it deems necessary, require quarterly financial statements from the guaranteeing organization.
(6) A health maintenance organization that is authorized in this state and one or more other states, jurisdictions, or countries is subject to ss. 624.4085 and 624.40851.

641.285 Insolvency protection.—
(1) Each health maintenance organization shall deposit with the department cash or securities of the type eligible under s. 625.52, which shall have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually, or more often, as the office deems necessary. The market value of the deposit shall be a minimum of $300,000.
(2) If securities or assets deposited by a health maintenance organization under this part are subject to material fluctuations in market value, the office may, in its discretion, require the organization to deposit and maintain on deposit additional securities or assets in an amount as may be reasonably necessary to assure that the deposit will at all times have a market value of not less than the amount specified under this section. If for any reason the

market value of assets and securities of a health maintenance organization held on deposit in this state under this code falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency. If the health maintenance organization has failed to cure the deficiency within 30 days after receipt of notice thereof by registered or certified mail from the office, the office may revoke the certificate of authority of the health maintenance organization.
(3) Whenever the office determines that the financial condition of a health maintenance organization has deteriorated to the point that the policyholders' or subscribers' best interests are not being preserved by the activities of a health maintenance organization, the office may require such health maintenance organization to deposit and maintain deposited in trust with the department for the protection of the health maintenance organization's policyholders, subscribers, and creditors, for such time as the office deems necessary, securities eligible for such deposit under s. 625.52 having a market value of not less than the amount that the office determines is necessary, which amount must not be less than $100,000 or greater than $2 million. The deposit required under this subsection is in addition to any other deposits required of a health maintenance organization pursuant to subsections (1) and (2).
(4) All income from deposits shall belong to the depositing health maintenance organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash or eligible securities or any combination of these or other acceptable measures of equal amount and value.

641.26 Annual and quarterly reports.—
(1) Every health maintenance organization shall, annually within 3 months after the end of its fiscal year, or within an extension of time therefor as the office, for good cause, may grant, in a form prescribed by the commission, file a report with the office, verified by the oath of two officers of the organization or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, properly notarized, showing its condition on the last day of the immediately preceding reporting period. Such report shall include:
(a) A financial statement of the health maintenance organization filed by electronic means in a computer-readable form using a format acceptable to the office.
(b) A financial statement of the health maintenance organization filed on forms acceptable to the office.
(c) An audited financial statement of the health maintenance organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles.
(d) The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated.
(e) The number and amount of damage claims for medical injury initiated against the health maintenance organization and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.
(f) An actuarial certification that:
1. The health maintenance organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization.
2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.
4. The health maintenance organization has adequately provided for all obligations required by s. 641.35(3)(a).
(g) A report prepared by the certified public accountant and filed with the office describing material weaknesses in the health maintenance organization's internal control structure as noted by the certified public accountant during the audit. The report must be filed with the annual audited financial report as required in paragraph (c). The health maintenance organization shall provide a description of remedial actions taken or proposed to correct material weaknesses, if the actions are not described in the independent certified public accountant's report.
(h) Such other information relating to the performance of health maintenance organizations as is required by the commission or office.
(2) The office may require updates of the actuarial certification as to a particular health maintenance organization if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the health maintenance organization. Workpapers in support of the statement of the updated actuarial certification must be provided to the office upon request.

641.27 Examination by the department.—
(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 years. However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. In no event shall expenses of all examinations exceed a maximum of $50,000 for any 1-year period. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, reorganization, conservation, or dissolution of life insurance companies.
(2) The office may contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform audits or examinations or portions thereof pertaining to the qualification of an entity for issuance of a certificate of authority or to determine continued compliance with the requirements of this part, in which case the payment must be made directly to the contracted examiner by the health maintenance organization examined, in accordance with the rates and terms agreed to by the office and the examiner. Any contracted assistance shall be under the direct supervision of the office. The results of any contracted assistance shall be subject to the review of, and approval, disapproval, or modification by, the office.

641.29 Fees.—Every health maintenance organization shall pay to the office the following fees:
(1) For filing a copy of its application for a certificate of authority or amendment thereto, a nonrefundable fee in the amount of $1,000.

(2) For filing each annual report, which must be filed by electronic means in a computer-readable form, $150.

641.3007 HIV infection and AIDS for contract purposes.—

(4) UTILIZATION OF MEDICAL TESTS.—

(b) Prior to testing, the health maintenance organization must disclose its intent to test the person for the HIV infection or for a specific sickness or medical condition derived therefrom and must obtain the person's written informed consent to administer the test. Written informed consent shall include a fair explanation of the test, including its purpose, potential uses, and limitations, and the meaning of its results and the right to confidential treatment of information. Use of a form approved by the office shall raise a conclusive presumption of informed consent.
(c) An applicant shall be notified of a positive test result by a physician designated by the applicant or, in the absence of such designation, by the Department of Health. Such notification must include:
1. Face-to-face posttest counseling on the meaning of the test results; the possible need for additional testing; and the need to eliminate behavior which might spread the disease to others;
2. The availability in the geographic area of any appropriate health care services, including mental health care, and appropriate social and support services;
3. The benefits of locating and counseling any individual by whom the infected individual may have been exposed to human immunodeficiency virus and any individual whom the infected individual may have exposed to the virus; and
4. The availability, if any, of the services of public health authorities with respect to locating and counseling any individual described in subparagraph 3.

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.
(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the office the proposed change or amendment. Any proposed change shall be effective immediately, subject to disapproval by the office. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or use any form disapproved by the office or as to which the office has withdrawn approval.
(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group.

(c) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:
1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.
2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. Has any title, heading, or other indication of its provisions which is misleading.
4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.
5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.
6. Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.
(d) Any change in rates charged for the contract must be filed with the office not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the office. The approval of the filing by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved. This paragraph does not apply to group health contracts effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(e) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(5) Every subscriber shall receive a clear and understandable description of the method of the health maintenance organization for resolving subscriber grievances, and the method shall be set forth in the contract, certificate, and member handbook. The organization shall also furnish, at the time of initial enrollment and when necessary due to substantial changes to the grievance process a separate and additional communication prepared or approved by the office notifying the contract holder of a group contract or subscriber of an individual contract of their rights and responsibilities under the grievance process.

641.31074 Guaranteed renewability of coverage.—
(1) Except as otherwise provided in this section, a health maintenance organization that issues a health insurance contract must renew or continue in force such coverage at the option of the contract holder.
(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:
(a) The contract holder has failed to pay premiums or contributions in accordance with the terms of the contract or the health maintenance organization has not received timely premium payments.

(b) The contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.
(c) The contract holder has failed to comply with a material provision of the plan which relates to rules for employer contributions or group participation.
(d) The health maintenance organization is ceasing to offer coverage in such a market in accordance with subsection (3).
(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business.
(f) In the case of coverage that is made available only through one or more bona fide associations as defined in s. 627.6571(5), the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.
(3)(a) A health maintenance organization may discontinue offering a particular contract form only if:
1. The health maintenance organization provides notice to each contract holder provided coverage of this form in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least 90 days prior to the date of the nonrenewal of such coverage;
2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health maintenance organization in such market; and
3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the health maintenance organization acts uniformly without regard to the claims experience of those contract holders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.
(b)1. In any case in which a health maintenance organization elects to discontinue offering all coverage in the individual market, the small group market, the large group market, or any combination thereof in this state, coverage may be discontinued by the insurer only if:
a. The health maintenance organization provides notice to the office and to each contract holder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in a market, the health maintenance organization may not provide for the issuance of any health maintenance organization contract coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance contract not renewed.
(4) At the time of coverage renewal, a health maintenance organization may modify the coverage for a product offered:
(a) In the large group market;
(b) In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, as defined in s. 627.6571(5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product; or
(c) In the individual market if the modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.
(5) In applying this section in the case of health insurance coverage that is made available by a health maintenance organization in the small group market or large group market to

employers only through one or more associations, a reference to "contract holder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

641.3922 Conversion contracts; conditions

(3) CONVERSION PREMIUM.—The premium for the converted contract shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of coverage provided. However, the premium for the converted contract may not exceed 200 percent of the standard risk rate, as established by the office under s. 627.6675(3). The mode of payment for the converted contract shall be quarterly or more frequently at the option of the organization, unless otherwise mutually agreed upon between the subscriber and the organization.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

627.6425 Renewability of individual coverage.—
(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this section, the term "individual health insurance" means health insurance coverage, as described in s. 624.603, offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14).
(2) An insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:
(a) The individual has failed to pay premiums, contributions, or a required copayment payable to the insurer in accordance with the terms of the health insurance coverage or the insurer has not received timely premium payments. When the copayment is payable to the insurer and exceeds $300, the insurer shall allow the insured up to 90 days after the date of the procedure to pay the required copayment. The insurer shall print in 10-point type on the Declaration of Benefits page notification that the insured could be terminated for failure to make any required copayment to the insurer.
(b) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
(c) The insurer is ceasing to offer coverage in the individual market in accordance with subsection (3) and applicable state law.
(d) In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered individuals.
(e) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, as defined in s. 627.6571(5), the membership of the individual in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered individuals.
(3)(a) If an insurer decides to discontinue offering a particular policy form for health insurance coverage offered in the individual market, coverage under such form may be discontinued by the insurer only if:
1. The insurer provides notice to each covered individual provided coverage under this policy form in the individual market of such discontinuation at least 90 days before the date of the nonrenewal of such coverage;

2. The insurer offers to each individual in the individual market provided coverage under this policy form the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in such market in the state; and
3. In exercising the option to discontinue coverage of a policy form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage. If a policy form covers both grandfathered and nongrandfathered health plans, an insurer may nonrenew coverage only for the nongrandfathered health plans, in which case the requirements of subparagraphs 1. and 2. apply only to the nongrandfathered health plans. As used in this subparagraph, the terms "grandfathered health plan" and "nongrandfathered health plan" have the same meaning as provided in s. 627.402.
(b)1. Subject to subparagraph (a)3., in any case in which an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if:
a. The insurer provides notice to the office and to each individual of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in the state in the individual market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in the individual market, the insurer may not provide for the issuance of any individual health insurance coverage in this state during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.
(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.
(5) In applying this section in the case of health insurance coverage that is made available by an insurer in the individual market to individuals only through one or more associations, a reference to an "individual" includes a reference to such an association of which the individual is a member.
(6) This section applies to health insurance coverage offered, sold, issued, or renewed in the individual market on or after July 1, 1997.

627.6692 Florida Health Insurance Coverage Continuation Act.—

(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.—
(a) A group health plan issued to a small employer must provide that each qualified beneficiary who would lose coverage under the group health plan because of a qualifying event is entitled, without evidence of insurability, to elect, within the election period provided in this section, continuation coverage under the employer's group health plan. A qualified beneficiary who elects continuation coverage is subject to all the terms and conditions applicable under the group health plan.
(b) Coverage under the group health plan must, at a minimum, extend for the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:
1. The date that is 18 months after the date on which the qualified beneficiary's benefits under the group health plan would otherwise have ceased because of a qualifying event.
2. The date on which coverage ceases under the group health plan by reason of a failure to make timely payment of the applicable premium with respect to any qualified beneficiary.
3. The date a qualified beneficiary becomes covered under any other group health plan, if the qualified beneficiary will not be subject to any exclusion or limitation because of a preexisting condition of that beneficiary.

4. The date a qualified beneficiary is entitled to benefits under either part A or part B of Title XVIII of the Social Security Act (Medicare).
5. The date on which the employer terminates coverage under the group health plan for all employees. If the employer terminates coverage under the group health plan for all employees and if such group health plan is replaced by similar coverage under another group health plan, the qualified beneficiary shall have the right to become covered under the new group health plan for the balance of the period that she or he would have remained covered under the prior group health plan. A qualified beneficiary is to be treated in the same manner as an active beneficiary for whom a qualifying event has not taken place.
(c) A qualified beneficiary who is determined, under Title II or Title XVI of the Social Security Act, to have been disabled at the time of a qualifying event, may be eligible to continue coverage for an additional 11 months (29 months total) if the qualified beneficiary provides the written determination of disability from the Social Security Administration to the insurance carrier within 60 days of the date of determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The insurance carrier can charge up to 150 percent of the group rate during the 11-month disability extension. The qualified beneficiary must notify the insurance carrier within 30 days upon the determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act.
(d)1. A qualified beneficiary must give written notice to the insurance carrier within 63 days after the occurrence of a qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary constitutes notice on behalf of all qualified beneficiaries. The written notice must inform the insurance carrier of the occurrence and type of the qualifying event giving rise to the potential election by a qualified beneficiary of continuation of coverage under the group health plan issued by that insurance carrier, except that in cases where the covered employee has been involuntarily discharged, the nature of such discharge need not be disclosed. The written notice must, at a minimum, identify the employer, the group health plan number, the name and address of all qualified beneficiaries, and such other information required by the insurance carrier under the terms of the group health plan or the commission by rule, to the extent that such information is known by the qualified beneficiary.
2. Within 14 days after the receipt of written notice under subparagraph 1., the insurance carrier shall send each qualified beneficiary by certified mail an election and premium notice form, approved by the office, which form must provide for the qualified beneficiary's election or nonelection of continuation of coverage under the group health plan and the applicable premium amount due after the election to continue coverage. This subparagraph does not require separate mailing of notices to qualified beneficiaries residing in the same household, but requires a separate mailing for each separate household.
(e)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 30 days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due date on the first of the month of coverage and allowing a 30-day grace period for payment.
2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the

group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.
(f) The premium paid for continuation of coverage may not exceed 115 percent of the applicable premium.
(g) If an insurance carrier fails to comply with the notice requirements of subparagraph (d)2. and such noncompliance results in the failure of an eligible qualified beneficiary to elect continuation under the group health plan, the qualified beneficiary shall be deemed to have timely elected continuation of coverage within the election period and shall be covered under the group health plan at the expense of the noncomplying insurance carrier. The liability exposure of a noncomplying insurance carrier under this paragraph shall be limited to that period which includes the effective date of coverage pursuant to an affirmative election through the date on which the qualified beneficiary receives actual notice. This paragraph does not apply to the extent that the failure of the insurance carrier to comply with applicable notice requirements was due to noncompliance by the qualified beneficiary with notice requirements applicable to the qualified beneficiary.
(h) If a covered employee is in the military reserve or National Guard and is called to active duty and the employee's employment is terminated either after or during the active duty period, the termination is a separate qualifying event, distinct from the qualifying event that may have occurred when the employee was called to active duty, and the employee and other qualified beneficiaries are eligible for a new 18-month benefit period beginning on the later of the date active duty ends or the date of termination of employment.
(i) If a covered employee is in the military reserve or National Guard and is called to active duty and:
1. The employee dies during the period of active duty,
2. There is a divorce or legal separation of the covered employee from the covered employee's spouse, or
3. A dependent child ceases to be a dependent child under the requirements of the employer's group health plan,

such events are qualifying events distinct from the qualifying event that may have occurred when the employee was called to active duty.

(j) Notwithstanding paragraph (b), if a qualified beneficiary in the military reserve or National Guard has elected to continue coverage and is thereafter called to active duty and the coverage under the group plan is terminated by the beneficiary or the carrier due to the qualified beneficiary becoming eligible for TRICARE (the health care program provided by the United States Defense Department), the 18-month period or such other applicable maximum time period for which the qualified beneficiary would otherwise be entitled to continue coverage is tolled during the time that he or she is covered under the TRICARE program. Within 63 days after the federal TRICARE coverage terminates, the qualified beneficiary may elect to continue coverage under the group health plan, retroactively to the date coverage terminated under TRICARE, for the remainder of the 18-month period or such other applicable time period, subject to termination of coverage at the earliest of the conditions specified in paragraph (b).

(9) RULES.—The commission shall adopt rules establishing standards for the initial notice of rights and as otherwise necessary to administer this section.

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

[1]627.410 Filing, approval of forms.—
(1) A basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, may not be delivered or issued for delivery in this state unless the form has been filed with the office by or on behalf of the insurer that proposes to use such form and has been approved by the office or filed pursuant to s. 627.4102. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character that are designed for and used with insurance on a particular subject, other than as to health insurance, or that relate to the manner of distributing benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. For group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the office for information purposes only.
(2) Every such filing must be made at least 30 days in advance of any such use or delivery. At the expiration of the 30 days, the form filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend the period within which it may affirmatively approve or disapprove such form by up to 15 days by giving notice of such extension before expiration of the initial 30-day period. At the expiration of such extended period, and in the absence of prior affirmative approval or disapproval, such form shall be deemed approved.
(3) The office may, for cause, withdraw a previous approval. No insurer shall issue or use any form disapproved by the office, or as to which the office has withdrawn approval, after the effective date of the order of the office.
(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.
(5) This section also applies to any such form used by domestic insurers for delivery in a jurisdiction outside this state if the insurance supervisory official of such jurisdiction informs the office that such form is not subject to approval or disapproval by such official, and upon the order of the office requiring the form to be submitted to it for the purpose. The applicable same standards apply to such forms as apply to forms for domestic use.
(6)(a) An insurer may not deliver, issue for delivery, or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health

insurance policy form or type thereof, as specified in such rule, to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 are for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period, and shall be deemed to be approved under the same conditions, as provided in subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, is prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions that classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form is not considered to be available for purchase unless the insurer has actively offered it for sale during the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing at least 30 days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may no longer offer the policy form or certificate form for sale in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may not file for approval a new policy form providing benefits similar to the discontinued form for 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form because it does not comply with PPACA.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that the experience of grandfathered health plans and nongrandfathered health plans shall be separated.

(7) Each insurer subject to subsection (6) shall make an annual filing with the office within 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(a) The filing shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted by the commission.

2. If no rate change is proposed, a filing that consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(b) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(c) If at the time a filing is required an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by the date the filing is due.
(d) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made until such time as the office determines that the required filing is properly submitted.
(8)(a) For the purposes of subsections (6) and (7), benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the office, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The office shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the office may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.
(b) The renewal premium rates shall be deemed to be approved upon filing with the office if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:
1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.
2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.
3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the office no later than the end of such quarter. The commission shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.
4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund

shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the office has adequate time to review the report.
5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the office, shall withdraw the policy form for the purposes of issuing new policies.
(c) As used in this subsection:
1. "Loss ratio" means the ratio of incurred claims to earned premium.
2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio.
3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

627.6571 Guaranteed renewability of coverage.—

(3) (b)1. In any case in which an insurer elects to discontinue offering all health insurance coverage in the small-group market or the large-group market, or both, in this state, health insurance coverage may be discontinued by the insurer only if:

a. The insurer provides notice to the office and to each policyholder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in a market, the insurer may not provide for the issuance of any health insurance coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance coverage not renewed.
(c) A mailing to one household constitutes a mailing to all covered persons residing in that household. A separate mailing is required for each separate household.

641.31074 Guaranteed renewability of coverage.—
(1) Except as otherwise provided in this section, a health maintenance organization that issues a health insurance contract must renew or continue in force such coverage at the option of the contract holder.
(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:
(a) The contract holder has failed to pay premiums or contributions in accordance with the terms of the contract or the health maintenance organization has not received timely premium payments.
(b) The contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.

(c) The contract holder has failed to comply with a material provision of the plan which relates to rules for employer contributions or group participation.
(d) The health maintenance organization is ceasing to offer coverage in such a market in accordance with subsection (3).
(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business.
(f) In the case of coverage that is made available only through one or more bona fide associations as defined in s. 627.6571(5), the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.
(3)(a) A health maintenance organization may discontinue offering a particular contract form only if:
1. The health maintenance organization provides notice to each contract holder provided coverage of this form in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least 90 days prior to the date of the nonrenewal of such coverage;
2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health maintenance organization in such market; and
3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the health maintenance organization acts uniformly without regard to the claims experience of those contract holders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.
(b)1. In any case in which a health maintenance organization elects to discontinue offering all coverage in the individual market, the small group market, the large group market, or any combination thereof in this state, coverage may be discontinued by the insurer only if:
a. The health maintenance organization provides notice to the office and to each contract holder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in a market, the health maintenance organization may not provide for the issuance of any health maintenance organization contract coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance contract not renewed.
(4) At the time of coverage renewal, a health maintenance organization may modify the coverage for a product offered:
(a) In the large group market;
(b) In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, as defined in s. 627.6571(5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product; or
(c) In the individual market if the modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.
(5) In applying this section in the case of health insurance coverage that is made available by a health maintenance organization in the small group market or large group market to employers only through one or more associations, a reference to "contract holder" is

deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless

the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive

years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

69O-149 Rulemaking Authority

627.6699 Employee Health Care Access Act.—

(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—
(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years. Any carrier that is not a small employer carrier and intends to become a small employer carrier must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The office may permit a carrier to modify its election at any time for good cause shown, after a hearing.
(b) The commission shall establish an application process for small employer carriers seeking to change their status under this subsection.
(c) An election to become a risk-assuming carrier is subject to approval under subsection (10).
(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.
(10) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—
(a)1. A small employer carrier may become a risk-assuming carrier by filing with the office a designation of election under subsection (9) in a format and manner prescribed by the commission. The office shall approve the election of a small employer carrier to become a risk-assuming carrier if the office finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).
2. The office must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.
(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the office shall consider:
1. The carrier's financial ability to support the assumption of the risk of small employer groups.
2. The carrier's history of rating and underwriting small employer groups.
3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.
4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection (11).
(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection (11).
(d) The office shall provide public notice of a small employer carrier's designation of election under subsection (9) to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The office shall hold a hearing on the election at the request of the carrier.

(e) The office may rescind the approval granted to a risk-assuming carrier under this subsection if the office finds that the carrier no longer meets the criteria of paragraph (b).

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—
(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."
(b)1. The program shall operate subject to the supervision and control of the board.
2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:
a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration.
b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.
3. The director of the office may remove a member for cause.
4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.
(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the office any amendments to the plan that the board finds to be necessary or suitable.
2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).
3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.
(d) The plan of operation must, among other things:
1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.
2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.
3. Establish procedures for reinsuring risks.
4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.
5. Provide for any additional matters at the discretion of the board.
(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:
1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;
2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;

3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;
4. Periodic reports by carriers and agents concerning health benefit plans issued; and
5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.
(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:
1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.
2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.
3. Take any legal action necessary to avoid the payment of improper claims against the program.
4. Issue reinsurance policies, in accordance with the requirements of this act.
5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.
6. Establish actuarial functions as appropriate for the operation of the program.
7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.
8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.
9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.
10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.
(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:
1. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 60 days after the commencement of his or her coverage.
2. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan.
3. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.
4. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban

Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.
5. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.
6. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 3., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 3. which may not be ceded to the program.
7. The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.
8. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.
(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:
a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.
b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.
2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the office.
(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.
(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.
2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:
a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (m), risk-assuming carriers are

exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in

whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.

(l) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.

(m) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.

(n) The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.
2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.
3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.
4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.
5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

(16) RESTRICTIONS ON COVERAGE.—

(a) A plan under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion, as defined in s. 390.011(1), except if the pregnancy is the result of an act of rape or incest, or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of

death unless an abortion is performed. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied toward the plan.
(b) This subsection does not prohibit a plan from providing any person or entity with separate coverage for an abortion if such coverage is not purchased in whole or in part with state or federal funds.
(c) As used in this section, the term "state" means this state or any political subdivision of the state.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the

department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to

by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

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624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—
(1) STANDARDS.—The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

627.9408 Rules.—
(1) The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this part.
(2) The commission may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by

anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.9402 Purpose.—The purpose of this part is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

[1]627.410 Filing, approval of forms.—

(7) Each insurer subject to subsection (6) shall make an annual filing with the office within 12 months after its previous filing, demonstrating the reasonableness of benefits in relation

to premium rates. After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(a) The filing shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted by the commission.

2. If no rate change is proposed, a filing that consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(b) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(c) If at the time a filing is required an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by the date the filing is due.

(d) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

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624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.418 Suspension, revocation of certificate of authority for violations and special grounds.—
(1) The office shall suspend or revoke an insurer's certificate of authority if it finds that the insurer:
(a) Is in unsound financial condition.
(b) Is using such methods and practices in the conduct of its business as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.
(c) Has failed to pay any final judgment rendered against it in this state within 60 days after the judgment became final.
(d) No longer meets the requirements for the authority originally granted.
(2) The office may, in its discretion, suspend or revoke the certificate of authority of an insurer if it finds that the insurer:
(a) Has violated any lawful order or rule of the office or commission or any provision of this code.
(b) Has refused to be examined or to produce its accounts, records, and files for examination, or if any of its officers have refused to give information with respect to its affairs or to perform any other legal obligation as to such examination, when required by the office.
(c) Has for any line, class, or combination thereof, with such frequency as to indicate its general business practice in this state, without just cause refused to pay proper claims arising under its policies, whether any such claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person, or without just cause compels such insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.
(d) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted as to surplus lines insurers under part VIII of chapter 626.
(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, a felony relating to the transaction of insurance, in this state or in any other state, without regard to whether adjudication was withheld.
(f) Has a ratio of net premiums written to surplus as to policyholders that exceeds 4 to 1, and the office has reason to believe that the financial condition of the insurer endangers the interests of the policyholders. The ratio of net premiums written to surplus as to policyholders shall be on an annualized actual or projected basis. The ratio shall be based on

the insurer's current calendar year activities and experience to date or the insurer's previous calendar year activities and experience, or both, and shall be calculated to represent a 12-month period. However, the provisions of this paragraph do not apply to any insurance or insurer exempted from s. 624.4095.
(g) Is under suspension or revocation in another state.
(3) The insolvency or impairment of an insurer constitutes an immediate serious danger to the public health, safety, or welfare; and the office may, at its discretion, without prior notice and the opportunity for hearing immediately suspend the certificate of authority of an insurer upon a determination that:
(a) The insurer is impaired or insolvent; or
(b) Receivership, conservatorship, rehabilitation, or other delinquency proceedings have been initiated against the insurer by the public insurance supervisory official of any state.

624.4211 Administrative fine in lieu of suspension or revocation.—
(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.
(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.
(3) With respect to any knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed $40,000 for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 for all knowing and willful violations arising out of the same action. In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).
(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.

624.424 Annual statement and other information.—

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

627.331 Recording and reporting of loss, expense, and claims experience; rating information.—

627.331 Recording and reporting of loss, expense, and claims experience; rating information.—
(1) The commission may promulgate rules and statistical plans which shall thereafter be used by each insurer in the recording and reporting of its loss, expense, and claims experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the office in determining whether the insurer's activities comply with the applicable standards of this code.
(2) In promulgating such rules and plans, the commission shall give due consideration to the rating systems in use in this state and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it, except for motor vehicle insurance as otherwise provided by law.
(3) The office may designate one or more rating organizations or other agencies to assist it in gathering such experience and making compilations thereof; and such compilations shall be made available, subject to reasonable rules adopted by the commission, to insurers and rating organizations.

627.062 Rate standards.—
(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.
(2) As to all such classes of insurance:
(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:
1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.
2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).
3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.
(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:
1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.

(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.
5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.
6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.
(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.
(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.
(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.
(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:
1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or

2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.
(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.
(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:
a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.
b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.
2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.
3. An insurer may make only one filing per 12-month period under this paragraph.
4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.
(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.
(c) This subsection does not apply to private passenger motor vehicle insurance.
(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):
a. Excess or umbrella.
b. Surety and fidelity.
c. Boiler and machinery and leakage and fire extinguishing equipment.
d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.
f. Intellectual property and patent infringement liability.
g. Advertising injury and Internet liability insurance.
h. Property risks rated under a highly protected risks rating plan.
i. General liability.
j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.
k. Nonresidential multiperil.
l. Excess property.
m. Burglary and theft.
n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.
o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.
p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.
q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.
2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.
3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and

the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.
(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.
(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.
(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.
(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.
(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.
(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.171 Excess rates.—
(1) With written consent of the insured signed prior to the policy inception date and filed with the insurer, the insurer may use a rate in excess of the otherwise applicable filed rate on any specific risk. The signed consent form must include the filed rate as well as the excess rate for the risk insured, and a copy of the form must be maintained by the insurer for 3 years and be available for review by the office.
(2) An insurer may not use excess rates pursuant to this section for more than 10 percent of its commercial insurance policies written or renewed in each calendar year for any line of commercial insurance or for more than 5 percent of its personal lines insurance policies written or renewed in each calendar year for any line of personal insurance. In determining the 10-percent limitation for commercial insurance policies, the insurer shall exclude any workers' compensation policy that was written for an employer who had coverage in the

joint underwriting plan created by s. 627.311(5) immediately prior to the writing of the policy by the insurer and any workers' compensation policy that was written for an employer who had been offered coverage in the joint underwriting plan but who was written a policy by the insurer in lieu of accepting the joint underwriting plan policy. These workers' compensation policies shall be excluded from the 10-percent limitation for the first 3 years of coverage.

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624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.4143 Outline of coverage.—
(1) No private passenger automobile or basic homeowner policy shall be delivered or issued for delivery in this state unless an appropriate outline of coverage has been delivered prior to issuance of the policy or accompanies the policy when issued.
(2) The outline of coverage for a private passenger motor vehicle insurance policy shall contain all of the following:
(a) A brief description of the principal benefits and coverage provided in the policy, broken down by each class or type of coverage provided under the policy for which a premium is charged, and itemization of the applicable premium.
(b) A summary statement of the principal exclusions and limitations or reductions contained in the policy by class or type, including, but not limited to, deductibles, coinsurance, and any other limitations or reductions.
(c) A summary statement of any renewal or cancellation provisions.
(d) A description of the credit or surcharge plan that is being applied. The description may display numerical or alphabetical codes on the declarations page or premium notice to enable the insured to determine the reason or reasons why her or his policy is being surcharged or is receiving a credit.
(e) A list of any additional coverage provided through any rider or endorsement which accompanies the policy. The list shall contain a descriptive reference to each additional coverage, rather than solely a reference to a form or code number.
(f) The extent of coverage provided to the insured in the event of collision damage to a rental vehicle rented by the insured. The proof-of-insurance card required by s. 316.646 must also specify whether rental car coverage is provided, and may refer to the outline of coverage as to the details or extent of coverage.
(3) A basic homeowner, mobile home owner, dwelling, or condominium unit owner policy may not be delivered or issued for delivery in this state unless a comprehensive checklist of coverage on a form adopted by the commission and an appropriate outline of coverage have been delivered prior to issuance of the policy or accompanies the policy when issued. The commission shall, by rule, adopt a form for the checklist for each type of policy to which this subsection applies. Each form shall indicate that it was adopted by the commission.
(a) The checklist must contain a list of the standard provisions and elements that may typically be included in these policies, whether or not they are included in the particular policy being issued, in a format that allows the insurer to place a check mark next to the provisions elements that are included so that the consumer can see both what is included and what is not included in the policy. As an alternative to checking the boxes on the

checklist, an insurer may delete the check boxes from the form and replace them with text indicating whether the provision's elements are included or not. Limits of liability shall be listed for each item. The checklist must include, but is not limited to, the following:
1. Property coverage for the principal premises shown in the declarations.
2. Property coverage for other structures on the residence premises.
3. Whether the principal premises and other structures are insured against the following perils:
a. Fire.
b. Lightning.
c. Explosion.
d. Hurricane loss.
e. Nonhurricane wind loss.
f. Collapse.
g. Mold.
h. Sinkhole loss.
i. Vandalism.
4. Personal property coverage.
5. Whether personal property is insured against the following perils:
a. Fire.
b. Lightning.
c. Hurricane loss.
d. Nonhurricane wind loss.
e. Collapse.
f. Mold.
g. Sinkhole loss.
h. Theft.
6. The following additional coverages:
a. Debris removal.
b. Loss assessment.
c. Additional living expenses.
7. Personal liability coverage.
8. Medical payments coverage.
9. Discounts applied to the premium.
10. Deductibles for loss due to hurricane and loss to other perils.
11. Building ordinance or law coverage.
12. Replacement cost coverage.
13. Actual cash value coverage.
(b) The forms shall allow insurers to place other coverages on the checklists which may or may not be included in the insurer's policies.
(c) The outline of coverage must contain:
1. A brief description of the principal benefits and coverage provided in the policy, broken down by each class or type of coverage provided under the policy for which a premium is charged, and itemization of the applicable premium.
2. A summary statement of the principal exclusions and limitations or reductions contained in the policy by class or type, including, but not limited to, deductibles, coinsurance, and any other limitations or reductions.
3. A summary statement of any renewal or cancellation provisions.
4. A description of the credit or surcharge plan that is being applied. The description may display numerical or alphabetical codes on the declarations page or premium notice to enable the insured to determine the reason or reasons why her or his policy is being surcharged or is receiving a credit.
5. A summary of any additional coverage provided through any rider or endorsement that accompanies the policy.

(4) The outline of coverage for a private passenger motor vehicle policy is required only on the initial policy issued by an insurer. The outline of coverage and the checklist for a basic homeowner, mobile home owner, dwelling, or condominium unit owner policy is required on the initial policy and each renewal thereof issued by an insurer.
(5) An insurer must insert the following language on the outline of coverage:

"The following outline of coverage or checklist is for informational purposes only. Florida law prohibits this outline or checklist from changing any of the provisions of the insurance contract which is the subject of this outline. Any endorsement regarding changes in types of coverage, exclusions, limitations, reductions, deductibles, coinsurance, renewal provisions, cancellation provisions, surcharges, or credits will be sent separately."

(6) Neither this section nor the outline of coverage or checklist mandated by this section alters or modifies the terms of the insurance contract, creates a cause of action, or is admissible in any civil action.

627.701 Liability of insureds; coinsurance; deductibles.—
(1) A property insurer may issue an insurance policy or contract covering either real or personal property in this state which contains provisions requiring the insured to be liable as a coinsurer with the insurer issuing the policy for any part of the loss or damage by covered peril to the property described in the policy only if:
(a) The following words are printed or stamped on the face of the policy, or a form containing the following words is attached to the policy: "Coinsurance contract: The rate charged in this policy is based upon the use of the coinsurance clause attached to this policy, with the consent of the insured.";
(b) The coinsurance clause in the policy is clearly identifiable; and
(c) The rate for the insurance with or without the coinsurance clause is furnished the insured upon his or her request.
(2) Unless the office determines that the deductible provision is clear and unambiguous, a property insurer may not issue an insurance policy or contract covering real property in this state which contains a deductible provision that:
(a) Applies solely to hurricane losses.
(b) States the deductible as a percentage rather than as a specific amount of money.
(3)(a) Except as otherwise provided in this subsection, prior to issuing a personal lines residential property insurance policy, the insurer must offer alternative deductible amounts applicable to hurricane losses equal to $500, 2 percent, 5 percent, and 10 percent of the policy dwelling limits, unless the specific percentage deductible is less than $500. The written notice of the offer shall specify the hurricane deductible to be applied in the event that the applicant or policyholder fails to affirmatively choose a hurricane deductible. The insurer must provide such policyholder with notice of the availability of the deductible amounts specified in this subsection in a form approved by the office in conjunction with each renewal of the policy. The failure to provide such notice constitutes a violation of this code but does not affect the coverage provided under the policy.
(b) This subsection does not apply with respect to a deductible program lawfully in effect on June 14, 1995, or to any similar deductible program, if the deductible program requires a minimum deductible amount of no less than 2 percent of the policy limits.
(c) With respect to a policy covering a risk with dwelling limits of at least $100,000, but less than $250,000, the insurer may, in lieu of offering a policy with a $500 hurricane deductible as required by paragraph (a), offer a policy that the insurer guarantees it will not nonrenew for reasons of reducing hurricane loss for one renewal period and that contains up to a 2 percent hurricane deductible as required by paragraph (a).

(d) With respect to a policy covering a risk with dwelling limits of $250,000 or more, the insurer need not offer the $500 hurricane deductible as required by paragraph (a), but must, except as otherwise provided in this subsection, offer the other hurricane deductibles as required by paragraph (a).
(4)(a) Any policy that contains a separate hurricane deductible must on its face include in boldfaced type no smaller than 18 points the following statement: "THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU." A policy containing a coinsurance provision applicable to hurricane losses must on its face include in boldfaced type no smaller than 18 points the following statement: "THIS POLICY CONTAINS A CO-PAY PROVISION THAT MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU."
(b) For any personal lines residential property insurance policy containing a separate hurricane deductible, the insurer shall compute and prominently display the actual dollar value of the hurricane deductible on the declarations page of the policy at issuance and, for renewal, on the renewal declarations page of the policy or on the premium renewal notice.
(c) For any personal lines residential property insurance policy containing an inflation guard rider, the insurer shall compute and prominently display the actual dollar value of the hurricane deductible on the declarations page of the policy at issuance and, for renewal, on the renewal declarations page of the policy or on the premium renewal notice. In addition, for any personal lines residential property insurance policy containing an inflation guard rider, the insurer shall notify the policyholder of the possibility that the hurricane deductible may be higher than indicated when loss occurs due to application of the inflation guard rider. Such notification shall be made on the declarations page of the policy at issuance and, for renewal, on the renewal declarations page of the policy or on the premium renewal notice.
(d)1. A personal lines residential property insurance policy covering a risk valued at less than $500,000 may not have a hurricane deductible in excess of 10 percent of the policy dwelling limits, unless the following conditions are met:
a. The policyholder must personally write and provide to the insurer the following statement in his or her own handwriting and sign his or her name, which must also be signed by every other named insured on the policy, and dated: "I do not want the insurance on my home to pay for the first (specify dollar value) of damage from hurricanes. I will pay those costs. My insurance will not."
b. If the structure insured by the policy is subject to a mortgage or lien, the policyholder must provide the insurer with a written statement from the mortgageholder or lienholder indicating that the mortgageholder or lienholder approves the policyholder electing to have the specified deductible.
2. A deductible subject to the requirements of this paragraph applies for the term of the policy and for each renewal thereafter. Changes to the deductible percentage may be implemented only as of the date of renewal.
3. An insurer shall keep the original copy of the signed statement required by this paragraph, electronically or otherwise, and provide a copy to the policyholder providing the signed statement. A signed statement meeting the requirements of this paragraph creates a presumption that there was an informed, knowing election of coverage.
4. The commission shall adopt rules providing appropriate alternative methods for providing the statements required by this section for policyholders who have a handicapping or disabling condition that prevents them from providing a handwritten statement.
(5)(a) The hurricane deductible of any personal lines residential property insurance policy issued or renewed on or after May 1, 2005, shall be applied as follows:
1. The hurricane deductible shall apply on an annual basis to all covered hurricane losses that occur during the calendar year for losses that are covered under one or more policies issued by the same insurer or an insurer in the same insurer group.

2. If a hurricane deductible applies separately to each of one or more structures insured under a single policy, the requirements of this paragraph apply with respect to the deductible for each structure.
3. If there was a hurricane loss for a prior hurricane or hurricanes during the calendar year, the insurer may apply a deductible to a subsequent hurricane which is the greater of the remaining amount of the hurricane deductible or the amount of the deductible that applies to perils other than a hurricane. Insurers may require policyholders to report hurricane losses that are below the hurricane deductible or to maintain receipts or other records of such hurricane losses in order to apply such losses to subsequent hurricane claims.
4. If there are hurricane losses in a calendar year on more than one policy issued by the same insurer or an insurer in the same insurer group, the hurricane deductible shall be the highest amount stated in any one of the policies. If a policyholder who had a hurricane loss under the prior policy is provided or offered a lower hurricane deductible under the new or renewal policy, the insurer must notify the policyholder, in writing, at the time the lower hurricane deductible is provided or offered, that the lower hurricane deductible will not apply until January 1 of the following calendar year.
(b) For commercial residential property insurance policies issued or renewed on or after January 1, 2006, the insurer must offer the policyholder the following alternative hurricane deductibles:
1. A hurricane deductible that applies on an annual basis as provided in paragraph (a); and
2. A hurricane deductible that applies to each hurricane.
(6)(a) It is the intent of the Legislature to encourage the use of higher hurricane deductibles as a means of increasing the effective capacity of the hurricane insurance market in this state and as a means of limiting the impact of rapidly changing hurricane insurance premiums. The Legislature finds that the hurricane deductibles specified in this subsection are reasonable when a property owner has made adequate provision for restoration of the property to its full value after a catastrophic loss.
(b) A personal lines residential insurance policy providing hurricane coverage may, at the mutual option of the insured and insurer, include a secured hurricane deductible as described in paragraph (c) if the applicant presents the insurer a certificate of security as described in paragraph (d). An insurer may not directly or indirectly require a secured deductible under this subsection as a condition of issuing or renewing a policy. A certificate of security is not required with respect to an applicant who owns a 100 percent equity interest in the property.
(c) A secured hurricane deductible must include the substance of the following:
1. The first $500 of any claim, regardless of the peril causing the loss, is fully deductible.
2. With respect to hurricane losses only, the next $5,000 in losses are fully insured, subject only to a copayment requirement of 10 percent.
3. With respect to hurricane losses only, the remainder of the claim is subject to a deductible equal to a specified percentage of the policy dwelling limits in excess of the deductible allowed under former paragraph (3)(a) but no higher than 10 percent of the policy dwelling limits.
4. The insurer agrees to renew the coverage on a guaranteed basis for a period of years after initial issuance of the secured deductible equal to at least 1 year for each 2 percentage points of deductible specified in subparagraph 3. unless the policy is canceled for nonpayment of premium or the insured fails to maintain the certificate of security. Such renewal shall be at the same premium as the initial policy except for premium changes attributable to changes in the value of the property.
(d) The office shall draft and formally propose as a rule the form for the certificate of security. The certificate of security may be issued in any of the following circumstances:
1. A mortgage lender or other financial institution may issue a certificate of security after granting the applicant a line of credit, secured by equity in real property or other reasonable

security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. In the sole discretion of the mortgage lender or other financial institution, the line of credit may be issued to an applicant on an unsecured basis.

2. A licensed insurance agent may issue a certificate of security after obtaining for an applicant a line of credit, secured by equity in real property or other reasonable security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. The Florida Hurricane Catastrophe Fund shall negotiate agreements creating a financing consortium to serve as an additional source of lines of credit to secure deductibles. Any licensed insurance agent may act as the agent of such consortium.

3. Any person qualified to act as a trustee for any purpose may issue a certificate of security secured by a pledge of assets, with the restriction that the assets may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.

4. Any insurer, including any admitted insurer or any surplus lines insurer, may issue a certificate of security after issuing the applicant a policy of supplemental insurance that will pay for 100 percent of the deductible portion of insured construction or reconstruction after a hurricane loss.

5. Any other method approved by the office upon finding that such other method provides a similar level of security as the methods specified in this paragraph and that such other method has no negative impact on residential property insurance catastrophic capacity. The legislative intent of this subparagraph is to provide the flexibility needed to achieve the public policy of expanding property insurance capacity while improving the affordability of property insurance.

(e) An issuer of a certificate of security may terminate the certificate for failure to honor any of the terms of the underlying financial arrangement. The issuer must provide notice of termination to the insurer within 10 working days after termination. Unless the policyholder obtains a replacement certificate of security within an additional 20 working days after such notice, the deductible provision in the policy must revert to a lower deductible otherwise offered by the insurer and the policyholder is responsible for any additional premium required for a policy with such deductible.

(7) Prior to issuing a personal lines residential property insurance policy on or after April 1, 1997, or prior to the first renewal of a residential property insurance policy on or after April 1, 1997, the insurer must offer a deductible equal to $500 applicable to losses from perils other than hurricane. The insurer must provide the policyholder with notice of the availability of the deductible specified in this subsection in a form approved by the office at least once every 3 years. The failure to provide such notice constitutes a violation of this code but does not affect the coverage provided under the policy. An insurer may require a higher deductible only as part of a deductible program lawfully in effect on June 1, 1996, or as part of a similar deductible program.

(8) Notwithstanding the other provisions of this section or of other law, but only as to hurricane coverage as defined in s. 627.4025 for commercial lines residential coverages, an insurer may offer a deductible in an amount not exceeding 10 percent of the insured value if, at the time of such offer and at each renewal, the insurer also offers to the policyholder a deductible in the amount of 3 percent of the insured value. Nothing in this subsection prohibits any deductible otherwise authorized by this section. All forms by which the offers authorized in this subsection are made or required to be made shall be on forms that are adopted or approved by the commission or office.

(9) With respect to hurricane coverage provided in a policy of residential coverage, when the policyholder has taken appropriate hurricane mitigation measures regarding the residence covered under the policy, the insurer shall provide the insured the option of

selecting an appropriate reduction in the policy's hurricane deductible or selecting the appropriate discount credit or other rate differential as provided in s. 627.0629. The insurer must provide the policyholder with notice of the options available under this subsection on a form approved by the office.

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624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.
(2) The department shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code. The office shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code.
(3) The department or office may conduct such investigations of insurance matters, in addition to investigations expressly authorized, as it may deem proper to determine whether any person has violated any provision of this code within its respective regulatory jurisdiction or to secure information useful in the lawful administration of any such provision. The cost of such investigations shall be borne by the state.
(4) The department and office may each collect, propose, publish, and disseminate information relating to the subject matter of any duties imposed upon it by law.
(5) The department and office shall each have such additional powers and duties as may be provided by other laws of this state.
(6) The department and office may each employ actuaries who shall be at-will employees and who shall serve at the pleasure of the Chief Financial Officer, in the case of department employees, or at the pleasure of the director of the office, in the case of office employees. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society and shall be exempt from the Career Service System established under chapter 110. The salaries of the actuaries employed pursuant to this paragraph shall be set in accordance with [1]s. 216.251(2)(a)5. and shall be set at levels which are commensurate with salary levels paid to actuaries by the insurance industry.
(7) The office, within existing resources, may expend funds for the professional development of its employees, including, but not limited to, professional dues for employees who are required to be members of professional organizations; examinations leading to professional designations required for employment with the office; training courses and examinations provided through, and to ensure compliance with, the National Association of Insurance Commissioners; or other training courses related to the regulation of insurance.
(8) The office shall, within existing resources, develop and implement an outreach program for the purpose of encouraging the entry of additional insurers into the Florida market.
(9) Upon receiving service of legal process issued in any civil action or proceeding in this state against any regulated person or any unauthorized insurer under s. 626.906 or s. 626.937 which is required to appoint the Chief Financial Officer as its attorney to receive service of all legal process, the Chief Financial Officer, as attorney, may, in lieu of sending the process by registered or certified mail, send the process or make it available by any other verifiable means, including, but not limited to, making the documents available by electronic transmission from a secure website established by the department to the person last designated by the regulated person or the unauthorized insurer to receive the process. When process documents are made available electronically, the Chief Financial Officer shall send a notice of receipt of service of process to the person last designated by the regulated person or unauthorized insurer to receive legal process. The notice must state the date and manner in which the copy of the process was made available to the regulated person or unauthorized insurer being served and contain the uniform resource locator (URL) for a hyperlink to access files and information on the department's website to obtain a copy of the process.
(10)(a) The Division of Consumer Services shall perform the following functions concerning products or services regulated by the department or office:
1. Receive inquiries and complaints from consumers.

2. Prepare and disseminate information that the department deems appropriate to inform or assist consumers.
3. Provide direct assistance to and advocacy for consumers who request such assistance or advocacy.
4. With respect to apparent or potential violations of law or applicable rules committed by a person or entity licensed by the department or office, report apparent or potential violations to the office or to the appropriate division of the department, which may take any additional action it deems appropriate.
5. Designate an employee of the division as the primary contact for consumers on issues relating to sinkholes.
(b) Any person licensed or issued a certificate of authority by the department or the office shall respond, in writing, to the division within 20 days after receipt of a written request for information from the division concerning a consumer complaint. The response must address the issues and allegations raised in the complaint. The division may impose an administrative penalty for failure to comply with this paragraph of up to $2,500 per violation upon any entity licensed by the department or the office and $250 for the first violation, $500 for the second violation, and up to $1,000 for the third or subsequent violation upon any individual licensed by the department or the office.
(c) The department may adopt rules to administer this subsection.
(d) The powers, duties, and responsibilities expressed or granted in this subsection do not limit the powers, duties, and responsibilities of the department, the Financial Services Commission, the Office of Insurance Regulation, or the Office of Financial Regulation as otherwise provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require

semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the

insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is

immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.062 Rate standards.—
(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.
(2) As to all such classes of insurance:
(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:
1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day

period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.
2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).
3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.
(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:
1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.
(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.
(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:
1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.
3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.
5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.
6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.
(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.
(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase

filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.
(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.
(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:
1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or
2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.
(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.
(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:
a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.
b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.
2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.
3. An insurer may make only one filing per 12-month period under this paragraph.
4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on

each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):

a. Excess or umbrella.

b. Surety and fidelity.

c. Boiler and machinery and leakage and fire extinguishing equipment.

d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.

f. Intellectual property and patent infringement liability.

g. Advertising injury and Internet liability insurance.

h. Property risks rated under a highly protected risks rating plan.

i. General liability.

j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.

k. Nonresidential multiperil.

l. Excess property.

m. Burglary and theft.

n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.

o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.

p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.

q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.

2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.

3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date

of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.
(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.
(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.
(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.
(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.
(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.

(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.
(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change

627.0651 Making and use of rates for motor vehicle insurance.—
(1) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on motor vehicle insurance written in this state. A copy of rates, rating schedules, and rating manuals, and changes therein, shall be filed with the office under one of the following procedures:
(a) If the filing is made at least 60 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, such filing shall be considered a "file and use" filing. In such case, the office shall initiate proceedings to disapprove the rate and so notify the insurer or shall finalize its review within 60 days after receipt of the filing. Notification to the insurer by the office of its preliminary findings shall toll the 60-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue notice to the insurer of its preliminary findings within 60 days after the filing.
(b) If the filing is not made in accordance with the provisions of paragraph (a), such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in subsection (11).
(2) Upon receiving notice of a rate filing or rate change, the office shall review the rate or rate change to determine if the rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall in accordance with generally accepted and reasonable actuarial techniques consider the following factors:
(a) Past and prospective loss experience within and outside this state.
(b) The past and prospective expenses.
(c) The degree of competition among insurers for the risk insured.
(d) Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. Such investment income shall not include income from invested surplus. The commission may adopt rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to motor vehicle insurance policies written in this state and the manner in which such investment income is used in the calculation of insurance rates. Such manner shall contemplate the use of a positive underwriting profit allowance in the rates that will be compatible with a reasonable rate of return plus provisions for contingencies. The total of the profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.066. In adopting such rules, the commission shall in all instances adhere to and implement the provisions of this paragraph.
(e) The reasonableness of the judgment reflected in the filing.
(f) Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.
(g) The cost of repairs to motor vehicles.
(h) The cost of medical services, if applicable.
(i) The adequacy of loss reserves.
(j) The cost of reinsurance.
(k) Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
(l) Other relevant factors which impact upon the frequency or severity of claims or upon expenses.
(3) Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

(4) Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when such replenishment is attributable to investment losses.
(5)(a) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
(b) The office has the responsibility to ensure that rates for private passenger vehicle insurance are adequate. To that end, the commission shall adopt rules establishing standards defining inadequate rates on private passenger vehicle insurance as defined in s. 627.041(8). In the event that the office finds that a rate or rate change is inadequate, the office shall order that a new rate or rate schedule be thereafter filed by the insurer and shall further provide information as to the manner in which noncompliance of the standards may be corrected. When a violation of this provision occurs, the office shall impose an administrative fine pursuant to s. 624.4211.
(6) One rate shall be deemed unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses.
(7) Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as rates reflect the differences with reasonable accuracy.
(8) Rates are not unfairly discriminatory if averaged broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and the justification for its rate incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially sound. The office shall require that any rate filing resulting from the use of a single zip code as a rating territory does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.
(9) In reviewing the rate or rate change filed, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated herein.
(10) The office may, at any time, review a rate or rate change, the pertinent records of the insurer, and market conditions; and, if the office finds on a preliminary basis that the rate or rate change may be excessive, inadequate, or unfairly discriminatory, the office shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not increase the rate until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(11) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order for any "use and file" filing made in accordance with paragraph (1)(b), that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.
(12) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer shall not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements shall not be included in the insurer's rate base and shall not be utilized to justify a rate or rate change.
(13)(a) Underwriting rules not contained in rating manuals shall be filed for private passenger automobile insurance and homeowners insurance.
(b) The submission of rates, rating schedules, and rating manuals to the office by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this subsection for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating schedules, and rating manuals of such organization. All such information shall be available for public inspection, upon receipt by the office, during usual business hours.
(14)(a) Commercial motor vehicle insurance is not subject to subsection (1), subsection (2), or subsection (9) or s. 627.0645.
(b) The rates for insurance described in this subsection may not be excessive, inadequate, or unfairly discriminatory.
(c) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on commercial motor vehicle insurance written in this state.
(d) An insurer must notify the office of any changes to rates for type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for risks described in this subsection shall be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(e) A rating organization must notify the office of any changes to loss cost for the type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to subsection (1), subsection (2), or subsection (9) shall be maintained by the

rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the rate factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

627.066 Excessive profits for motor vehicle insurance prohibited.—
(1) As used herein:
(a) "Private passenger automobile business" means that insurance business that is written on a family automobile policy, standard automobile policy, or personal automobile or similar private passenger automobile policy written for personal use, as opposed to commercial automobile insurance business.
(b) "Cash" means coins, currency, checks, drafts, or money orders.
(2) Each Florida private passenger automobile insurer group shall file with the office, prior to July 1 of each year on forms prescribed by the commission, the following data for Florida private passenger automobile business. The data filed for the group shall be a consolidation of the data of the individual insurers of the group. The data shall include both voluntary and joint underwriting association business, as follows:
(a) Calendar-year total limits earned premium.
(b) Accident-year incurred losses and loss adjustment expenses.
(c) The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.
(d) Policyholder dividends incurred during the applicable calendar year.
(3)(a) Excessive profit has been realized if there has been an underwriting gain for the 3 most recent calendar-accident years combined which is greater than the anticipated underwriting profit plus 5 percent of earned premiums for those calendar-accident years.
(b) As used herein with respect to any 3-year period, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated by Florida business. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.
(4) Each insurer group shall also file a schedule of Florida private passenger automobile loss and loss adjustment experience for each of the 3 most recent accident years. The incurred losses and loss adjustment expenses shall be valued as of March 31 of the year following the close of the accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of three evaluations will be provided for each accident year. The first year to be so reported shall be accident year 1976, so that the reporting of 3 accident years will not take place until accident years 1977 and 1978 have become available.
(5) Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: The sum of the accident-year incurred losses and loss adjustment expenses as of March 31 of the following year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, will be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.
(6) For the 3 most recent calendar-accident years, the underwriting gain or loss will be compared to the anticipated underwriting profit.

(7) If the insurer group has realized an excessive profit, the office shall order a return of the excessive amounts after affording the insurer group an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded in all instances unless the insurer group affirmatively demonstrates to the office that the refund of the excessive amounts will render a member of the insurer group financially impaired or will render it insolvent under the provisions of the Florida Insurance Code.
(8) The excessive amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the voluntary private passenger automobile policyholders of record of the insurer group on December 31 of the final compilation year.
(9) Any excess profit of an insurance company offering motor vehicle insurance shall be returned to policyholders in the form of a cash refund or a credit towards the future purchase of insurance.
(10)(a) Cash refunds to policyholders may be rounded to the nearest dollar.
(b) Data in required reports to the office may be rounded to the nearest dollar.
(c) Rounding, if elected by the insurer group, shall be applied consistently.
(11)(a) Refunds shall be completed in one of the following ways:
1. If the insurer group elects to make a cash refund, the refund shall be completed within 60 days of entry of a final order indicating that excessive profits have been realized.
2. If the insurer group elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order indicating that excessive profits have been realized. If an insurer group has made this election but an insured thereafter cancels his or her policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund not later than 60 days after termination of such coverage.
(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the office that the refunds have been made.
(12) Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year in which it is incurred, for purposes of reporting under this section for subsequent years.

627.915 Insurer experience reporting.—
(1) Each insurer transacting private passenger automobile insurance in this state shall report certain information annually to the office. The information will be due on or before July 1 of each year. The information shall be divided into the following categories: bodily injury liability; property damage liability; uninsured motorist; personal injury protection benefits; medical payments; comprehensive and collision. The information given shall be on direct insurance writings in the state alone and shall represent total limits data. The information set forth in paragraphs (a)-(f) is applicable to voluntary private passenger and Joint Underwriting Association private passenger writings and shall be reported for each of the latest 3 calendar-accident years, with an evaluation date of March 31 of the current year. The information set forth in paragraphs (g)-(j) is applicable to voluntary private passenger writings and shall be reported on a calendar-accident year basis ultimately seven times at seven different stages of development.
(a) Premiums earned for the latest 3 calendar-accident years.
(b) Loss development factors and the historic development of those factors.
(c) Policyholder dividends incurred.
(d) Expenses for other acquisition and general expense.
(e) Expenses for agents' commissions and taxes, licenses, and fees.
(f) Profit and contingency factors as utilized in the insurer's automobile rate filings for the applicable years.
(g) Losses paid.
(h) Losses unpaid.

(i) Loss adjustment expenses paid.
(j) Loss adjustment expenses unpaid.

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624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.
(2) The department shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code. The office shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code.
(3) The department or office may conduct such investigations of insurance matters, in addition to investigations expressly authorized, as it may deem proper to determine whether any person has violated any provision of this code within its respective regulatory jurisdiction or to secure information useful in the lawful administration of any such provision. The cost of such investigations shall be borne by the state.
(4) The department and office may each collect, propose, publish, and disseminate information relating to the subject matter of any duties imposed upon it by law.
(5) The department and office shall each have such additional powers and duties as may be provided by other laws of this state.
(6) The department and office may each employ actuaries who shall be at-will employees and who shall serve at the pleasure of the Chief Financial Officer, in the case of department employees, or at the pleasure of the director of the office, in the case of office employees. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society and shall be exempt from the Career Service System established under chapter 110. The salaries of the actuaries employed pursuant to this paragraph shall be set in accordance with ½s. 216.251(2)(a)5. and shall be set at levels which are commensurate with salary levels paid to actuaries by the insurance industry.
(7) The office, within existing resources, may expend funds for the professional development of its employees, including, but not limited to, professional dues for employees who are required to be members of professional organizations; examinations leading to professional designations required for employment with the office; training courses and examinations provided through, and to ensure compliance with, the National Association of Insurance Commissioners; or other training courses related to the regulation of insurance.
(8) The office shall, within existing resources, develop and implement an outreach program for the purpose of encouraging the entry of additional insurers into the Florida market.
(9) Upon receiving service of legal process issued in any civil action or proceeding in this state against any regulated person or any unauthorized insurer under s. 626.906 or s. 626.937 which is required to appoint the Chief Financial Officer as its attorney to receive service of all legal process, the Chief Financial Officer, as attorney, may, in lieu of sending the process by registered or certified mail, send the process or make it available by any other verifiable means, including, but not limited to, making the documents available by electronic transmission from a secure website established by the department to the person last designated by the regulated person or the unauthorized insurer to receive the process. When process documents are made available electronically, the Chief Financial Officer shall send a notice of receipt of service of process to the person last designated by the regulated person or unauthorized insurer to receive legal process. The notice must state the date and manner in which the copy of the process was made available to the regulated person or unauthorized insurer being served and contain the uniform resource locator (URL) for a hyperlink to access files and information on the department's website to obtain a copy of the process.

(10)(a) The Division of Consumer Services shall perform the following functions concerning products or services regulated by the department or office:
1. Receive inquiries and complaints from consumers.
2. Prepare and disseminate information that the department deems appropriate to inform or assist consumers.
3. Provide direct assistance to and advocacy for consumers who request such assistance or advocacy.
4. With respect to apparent or potential violations of law or applicable rules committed by a person or entity licensed by the department or office, report apparent or potential violations to the office or to the appropriate division of the department, which may take any additional action it deems appropriate.
5. Designate an employee of the division as the primary contact for consumers on issues relating to sinkholes.
(b) Any person licensed or issued a certificate of authority by the department or the office shall respond, in writing, to the division within 20 days after receipt of a written request for information from the division concerning a consumer complaint. The response must address the issues and allegations raised in the complaint. The division may impose an administrative penalty for failure to comply with this paragraph of up to $2,500 per violation upon any entity licensed by the department or the office and $250 for the first violation, $500 for the second violation, and up to $1,000 for the third or subsequent violation upon any individual licensed by the department or the office.
(c) The department may adopt rules to administer this subsection.
(d) The powers, duties, and responsibilities expressed or granted in this subsection do not limit the powers, duties, and responsibilities of the department, the Financial Services Commission, the Office of Insurance Regulation, or the Office of Financial Regulation as otherwise provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. 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 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a

computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by

authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance

coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.418 Suspension, revocation of certificate of authority for violations and special grounds.—

(2) The office may, in its discretion, suspend or revoke the certificate of authority of an insurer if it finds that the insurer:
(a) Has violated any lawful order or rule of the office or commission or any provision of this code.
(b) Has refused to be examined or to produce its accounts, records, and files for examination, or if any of its officers have refused to give information with respect to its

affairs or to perform any other legal obligation as to such examination, when required by the office.
(c) Has for any line, class, or combination thereof, with such frequency as to indicate its general business practice in this state, without just cause refused to pay proper claims arising under its policies, whether any such claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person, or without just cause compels such insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.
(d) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted as to surplus lines insurers under part VIII of chapter 626.
(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, a felony relating to the transaction of insurance, in this state or in any other state, without regard to whether adjudication was withheld.
(f) Has a ratio of net premiums written to surplus as to policyholders that exceeds 4 to 1, and the office has reason to believe that the financial condition of the insurer endangers the interests of the policyholders. The ratio of net premiums written to surplus as to policyholders shall be on an annualized actual or projected basis. The ratio shall be based on the insurer's current calendar year activities and experience to date or the insurer's previous calendar year activities and experience, or both, and shall be calculated to represent a 12-month period. However, the provisions of this paragraph do not apply to any insurance or insurer exempted from s. 624.4095.
(g) Is under suspension or revocation in another state.

624.4211 Administrative fine in lieu of suspension or revocation.—
(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.
(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.
(3) With respect to any knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed $40,000 for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 for all knowing and willful violations arising out of the same action. In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).
(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.

624.604 "Property insurance" defined.—"Property insurance" is insurance on real or personal property of every kind and of every interest therein, whether on land, water, or in the air, against loss or damage from any and all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance may contain a provision for accidental death or injury as part of a multiple peril homeowner's policy. Such insurance, which is incidental to the property insurance, is not subject to the provisions of this code applicable to life or health insurance. Property insurance does not include title insurance, as defined in s. 624.608.

624.605 "Casualty insurance" defined.—
(1) "Casualty insurance" includes:
(a) Vehicle insurance.—Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal, or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability, or expense resulting from or incidental to ownership, maintenance, or use of any such vehicle, aircraft, or animal. As to land vehicles, the term also includes insurance providing for medical, hospital, surgical, and disability benefits to injured persons, and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of the legal liability of the insured, while in, entering, alighting from, adjusting, repairing, cranking, or being struck by a vehicle, if such insurance is issued as a part of a liability insurance contract.
(b) Liability insurance.—Insurance against legal liability for the death, injury, or disability of any human being, or for damage to property, with provision for medical, hospital, and surgical benefits to the injured persons, irrespective of the legal liability of the insured, when issued as a part of a liability insurance contract.
(c) Workers' compensation and employer's liability.—Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for death, disablement, or injury of employees.
(d) Burglary and theft.—Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal, or concealment, or from any attempt at any of the foregoing; including supplemental coverage for medical, hospital, surgical, and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers and documents, resulting from any cause.
(e) Personal property floater.—Insurance upon personal effects against loss or damage from any cause under a floater.
(f) Glass.—Insurance against loss or damage to glass, including its lettering, ornamentation, and fittings.
(g) Boiler and machinery.—Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery, and apparatus of any kind, whether or not insured; together with provision for medical, hospital, and surgical benefits to the injured persons, irrespective of the legal liability of the insured, when issued as an incidental coverage which is part of a liability insurance contract.
(h) Leakage and fire extinguishing equipment.—Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hose, pumps, and other fire extinguishing equipment or apparatus, water pipes or containers, or by water

entering through leaks or openings in buildings, and insurance against such loss or damage to such sprinklers, hose, pumps, and other fire extinguishing equipment or apparatus.
(i) Credit.—Insurance against loss or damage resulting from failure of debtors to pay their obligations to the creditor (including loss or damage resulting from the involuntary unemployment of the debtors), except insurance against loss or damage resulting from the death or disability of the debtors. However, insurance may not be written as credit insurance if it falls within the definition of financial guaranty insurance, as defined in s. 627.971.
(j) Credit property insurance.—Credit property insurance is a limited line of insurance providing coverage on personal property used as collateral for securing a loan or on personal property purchased under an installment sales agreement. Credit property insurance shall not be considered to be property insurance. The coverage shall be issued on an inland marine policy form, and coverage limits shall be restricted to the initial amount of the loan or the amount of the installment sale.
(k) Malpractice.—Insurance against legal liability of the insured, and against loss, damage, or expense incidental to a claim of such liability, arising out of the death, injury, or disablement of any person, or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary, or professional service.
(l) Animal.—Insurance against loss or damage to animals, and services of a veterinary for such animals.
(m) Elevator.—Insurance against loss of or damage to any property of the insured resulting from the ownership, maintenance, or use of elevators, except loss or damage by fire, together with provision for medical, hospital, and surgical benefits to injured persons, irrespective of the legal liability of the insured, when issued as an incidental coverage which is part of a liability insurance contract.
(n) Entertainments.—Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation thereof due to death, accidental injury, or sickness of performers, participants, directors, or other principals.
(o) Failure of certain institutions to record documents.—Insurance indemnifying banks, bankers, trust companies, and credit unions against loss from failure or omission to record as public records chattel mortgages and liens of every kind upon personal property, given, held, delivered, or possessed as security or collateral for loans, advances, debts, or obligations of all kinds, provided that such insurance does not indemnify intentional omission to comply with the law relating to the recording of liens upon motor vehicles, nor to the intentional omission to record mortgages upon real property.
(p) Failure to file certain personal property instruments.—With respect to persons and institutions other than those referred to in paragraph (o), insurance against loss resulting from failure to file or record written instruments affecting the title of, or creating a lien upon, personal property.
(q) Miscellaneous.—When first approved by the office as not being contrary to law or public policy nor covered by any other kind of insurance as defined in the code, insurance against liability for any other kind of loss or damage to person or property, properly a subject of insurance and not within any other kind of insurance as defined in this code.
(r) Insurance for debt cancellation products.—Insurance that a creditor may purchase against the risk of financial loss from the use of debt cancellation products with consumer loans or leases or retail installment contracts. Insurance for debt cancellation products is not liability insurance but is considered credit insurance only for the purposes of s. 631.52(4).
1. For purposes of this paragraph, the term "debt cancellation products" means loan, lease, or retail installment contract terms, or modifications to loan, lease, or retail installment contracts, under which a creditor agrees to cancel or suspend all or part of a

customer's obligation to make payments upon the occurrence of specified events and includes, but is not limited to, debt cancellation contracts, debt suspension agreements, and guaranteed asset protection contracts. However, the term does not include title insurance as defined in s. 624.608.
2. Debt cancellation products may be offered by financial institutions as defined in s. 655.005, insured depository institutions as defined in 12 U.S.C. s. 1813(c), and subsidiaries of such institutions, as provided in the financial institutions codes; by sellers as defined in s. 721.05, or by the parents, subsidiaries, or affiliated entities of sellers, in connection with the sale of timeshare interests; or by other business entities as specifically authorized by law, and such products are not insurance for purposes of the Florida Insurance Code.
(2) The provision of medical, hospital, surgical, and funeral benefits, and of coverage against accidental death or injury, as part of other insurance as stated under paragraphs (a) (vehicle), (b) (liability), (d) (burglary and theft), (g) (boiler and machinery), or (m) (elevator) of subsection (1) shall for all purposes be deemed to be the same kind of insurance to which it is incidental and shall not be subject to provisions of this code applicable to life or health insurance.

627.021 Scope of this part.—
(1) This part of this chapter applies only to property, casualty, and surety insurances on subjects of insurance resident, located, or to be performed in this state.
(2) This chapter does not apply to:
(a) Reinsurance, except joint reinsurance as provided in s. 627.311.
(b) Insurance against loss of or damage to aircraft, their hulls, accessories, or equipment, or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of aircraft.
(c) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies.
(d) Commercial inland marine insurance.
(e) Surplus lines insurance placed under the provisions of ss. 626.913-626.937.
(3) For the purposes of this chapter, all motor vehicle insurance shall be deemed to be casualty insurance only.
(4) This part does not apply to health insurance.

627.062 Rate standards.—
(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.
(2) As to all such classes of insurance:
(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:
1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be

deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.
2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).
3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.
(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:
1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.
(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.
(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that

portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.
(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:
1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or
2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.
(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.
(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:
a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.
b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.
2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.
3. An insurer may make only one filing per 12-month period under this paragraph.
4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason

for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.
(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.
(c) This subsection does not apply to private passenger motor vehicle insurance.
(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):
a. Excess or umbrella.
b. Surety and fidelity.
c. Boiler and machinery and leakage and fire extinguishing equipment.
d. Errors and omissions.
e. Directors and officers, employment practices, fiduciary liability, and management liability.
f. Intellectual property and patent infringement liability.
g. Advertising injury and Internet liability insurance.
h. Property risks rated under a highly protected risks rating plan.
i. General liability.
j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.
k. Nonresidential multiperil.
l. Excess property.
m. Burglary and theft.
n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.
o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.
p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.
q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.
2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.
3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination,

the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.
(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.
(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.
(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.
(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.
(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.
(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted

and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.
(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

627.0645 Annual filings.—
(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:
(a) Workers' compensation and employer's liability insurance;
(b) Insurance as defined in ss. 624.604 and 624.605, limited to coverage of commercial risks other than commercial residential multiperil; or
(c) Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.
(b) The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.
(3) The filing requirements of this section shall be satisfied by one of the following methods:
(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission.
(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.
(4) An insurer may satisfy the annual filing requirements of this section by being a member or subscriber of a licensed rating organization which complies with the requirements of this section.
(5) If an insurer does not employ or otherwise retain the services of an actuary, the insurer's rate filing or certification that rates are actuarially sound shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance

ratemaking. A rate filing or certification prepared by a consultant must be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.
(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.
(7) Nothing in this section limits the office's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.
(8) As used in this section, the term "actuary" means an individual who is a member of the Casualty Actuarial Society.
(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

627.0651 Making and use of rates for motor vehicle insurance.—
(1) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on motor vehicle insurance written in this state. A copy of rates, rating schedules, and rating manuals, and changes therein, shall be filed with the office under one of the following procedures:
(a) If the filing is made at least 60 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, such filing shall be considered a "file and use" filing. In such case, the office shall initiate proceedings to disapprove the rate and so notify the insurer or shall finalize its review within 60 days after receipt of the filing. Notification to the insurer by the office of its preliminary findings shall toll the 60-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue notice to the insurer of its preliminary findings within 60 days after the filing.
(b) If the filing is not made in accordance with the provisions of paragraph (a), such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in subsection (11).
(2) Upon receiving notice of a rate filing or rate change, the office shall review the rate or rate change to determine if the rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall in accordance with generally accepted and reasonable actuarial techniques consider the following factors:
(a) Past and prospective loss experience within and outside this state.
(b) The past and prospective expenses.
(c) The degree of competition among insurers for the risk insured.
(d) Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. Such investment income shall not include income from invested surplus. The commission may adopt rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to motor vehicle insurance policies written in this state and the manner in which such investment income is used in the calculation of insurance rates. Such manner shall contemplate the use of a positive underwriting profit allowance in the rates that will be compatible with a reasonable rate of return plus

provisions for contingencies. The total of the profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.066. In adopting such rules, the commission shall in all instances adhere to and implement the provisions of this paragraph.
(e) The reasonableness of the judgment reflected in the filing.
(f) Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.
(g) The cost of repairs to motor vehicles.
(h) The cost of medical services, if applicable.
(i) The adequacy of loss reserves.
(j) The cost of reinsurance.
(k) Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
(l) Other relevant factors which impact upon the frequency or severity of claims or upon expenses.
(3) Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
(4) Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when such replenishment is attributable to investment losses.
(5)(a) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
(b) The office has the responsibility to ensure that rates for private passenger vehicle insurance are adequate. To that end, the commission shall adopt rules establishing standards defining inadequate rates on private passenger vehicle insurance as defined in s. 627.041(8). In the event that the office finds that a rate or rate change is inadequate, the office shall order that a new rate or rate schedule be thereafter filed by the insurer and shall further provide information as to the manner in which noncompliance of the standards may be corrected. When a violation of this provision occurs, the office shall impose an administrative fine pursuant to s. 624.4211.
(6) One rate shall be deemed unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses.
(7) Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as rates reflect the differences with reasonable accuracy.
(8) Rates are not unfairly discriminatory if averaged broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and the justification for its rate incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially sound. The office shall require that any rate filing resulting from the use of a single zip code as a rating territory does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.
(9) In reviewing the rate or rate change filed, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated herein.

(10) The office may, at any time, review a rate or rate change, the pertinent records of the insurer, and market conditions; and, if the office finds on a preliminary basis that the rate or rate change may be excessive, inadequate, or unfairly discriminatory, the office shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not increase the rate until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(11) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order for any "use and file" filing made in accordance with paragraph (1)(b), that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(12) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer shall not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements shall not be included in the insurer's rate base and shall not be utilized to justify a rate or rate change.

(13)(a) Underwriting rules not contained in rating manuals shall be filed for private passenger automobile insurance and homeowners insurance.

(b) The submission of rates, rating schedules, and rating manuals to the office by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this subsection for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating schedules, and rating manuals of such organization. All such information shall be available for public inspection, upon receipt by the office, during usual business hours.

(14)(a) Commercial motor vehicle insurance is not subject to subsection (1), subsection (2), or subsection (9) or s. 627.0645.

(b) The rates for insurance described in this subsection may not be excessive, inadequate, or unfairly discriminatory.

(c) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on commercial motor vehicle insurance written in this state.
(d) An insurer must notify the office of any changes to rates for type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for risks described in this subsection shall be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(e) A rating organization must notify the office of any changes to loss cost for the type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to subsection (1), subsection (2), or subsection (9) shall be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the rate factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

627.221 Rating organizations; licensing; fee.—
(1) A person, whether located within or outside this state, may make application to the office for a license as a rating organization. As to property or inland marine insurance, the application shall be for such kinds of insurance or subdivisions thereof or classes of risk or a part or combination thereof as are specified in the application. As to casualty and surety insurances, the application shall be for such kinds of insurance or subdivisions thereof as are specified in the application. The applicant shall file with its application:
(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business;
(b) A list of its members and subscribers;
(c) The name and address of a resident of this state upon whom notices or orders of the office or process affecting such rating organization may be served; and
(d) A statement of its qualifications as a rating organization.

If the office finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, it shall issue a license specifying (in the case of a casualty or surety rating organization) the kinds of insurance or subdivisions thereof, or (in the case of a property insurance rating organization) the kinds of insurance or subdivisions thereof or classes of risk or a part or combination thereof, for which the applicant is authorized to act as a rating organization.

(2) Licenses issued pursuant to this section shall expire on the September 30 next following date of issuance and shall be subject to annual renewal.
(3) The fee for the license shall be in the amount specified therefor in s. 624.501. This fee, when collected, shall be deposited to the credit of the Insurance Regulatory Trust Fund.

627.301 Advisory organizations.—
(1) No advisory organization shall conduct its operations in this state unless and until it has filed with the office:
(a) A copy of its constitution, articles of incorporation, articles of agreement or of association, and bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals thereof;
(b) A list of its members and subscribers; and
(c) The name and address of a resident of this state upon whom notices or orders of the office or process may be served.
(2) Every such advisory organization shall notify the office promptly of every change in:
(a) Its constitution;
(b) Its articles of incorporation, agreement, or association;
(c) Its bylaws, rules and regulations governing the conduct of its business;
(d) The list of members and subscribers; and
(e) The name and address of the resident of this state designated by it upon whom notices or orders of the office or process affecting such organization may be served.
(3) No such advisory organization shall engage in any unfair or unreasonable practice with respect to such activities.

# M E M O R A N D U M

**DATE:** February 24, 2017

**TO:** David Altmaier, Commissioner, Office of Insurance Regulation

**THROUGH:** Anoush Brangaccio, General Counsel

**FROM:** Virginia Christy
Stephen Fredrickson

**SUBJECT:** Cabinet Agenda for March 14, 2017
Request for Approval to Publish Amendments to
Rule Repeals for Rules: 69O-167.015, 69O-171.004, 69O-176.022,
69O.185.007, 69O-189.007, F.A.C.
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed repeals be presented to the Cabinet aides on or before March 8, 2017 and to the Financial Services Commission on March 14, 2017, with a request to approve for publication the proposed rules.

These rules were identified for repeal due to repeal of the statutory authority or determined to be obsolete or unnecessary.

Sections 624.308(1), 624.307(1), 624.424(1)(c) 627.215, 627.913(1), 627.918(1), 627.745, 626.171, 635.081, 635.071(2), F.S., provide rulemaking authority and laws implemented for these rules.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

**69O-167.015 Home Structure Rating System Adopted.**

*Rulemaking Authority 624.308(1) FS., Ch. 2007-1, Laws of Florida, § 40; Ch. 2006-12, Laws of Florida, § 39. Law Implemented 624.307(1) FS., Ch. 2007-1, Laws of Florida, § 40. History–New 11-1-07 Repealed_____.*

~~**69O-167.015 Home Structure Rating System Adopted.**~~

~~(1) The Home Structure Rating System dated March 30, 2007, is hereby adopted as the Uniform Home Grading Scale and is incorporated by reference.~~

~~(2) The report is available for viewing or download at http://www.floir.com/pdf/HSRS_Report_Package_March302007.pdf.~~

*Rulemaking Authority 624.308(1) FS., Ch. 2007-1, Laws of Florida, § 40; Ch. 2006-12, Laws of Florida, § 39. Law Implemented 624.307(1) FS., Ch. 2007-1, Laws of Florida, § 40. History–New 11-1-07 Repealed_____.*

**69O-171.004 Reports of Information by Products Liability Insurers Required.**

*Specific Authority 624.308(1) FS. Law Implemented 624.307(1), 627.913(1), 627.918(1) FS. History–New 1-16-83, Amended 7-1-85, Formerly 4-59.04, 4-59.004, 4-171.004 Repealed_____.*

~~**69O-171.004 Reports of Information by Products Liability Insurers Required.**~~

~~(1) Any insurer authorized to write a policy of products liability insurance in the state shall report the information required by Section 627.913(1), Florida Statutes, or required by rule, by completing and submitting to the Office of Insurance Regulation the form OIR-305 "Products Liability Insurance Reporting Form" in accordance with the instructions provided therein.~~

~~(2) Reports for the preceding calendar year are due on or before April 15th of each year.~~

~~(3) Form OIR-305 shall take effect on the effective date of this rule.~~

*Specific Authority 624.308(1) FS. Law Implemented 624.307(1), 627.913(1), 627.918(1) FS. History–New 1-16-83, Amended 7-1-85, Formerly 4-59.04, 4-59.004, 4-171.004 Repealed _____.*

**69O-176.022 Mediation of Bodily Injury and Property Damage Claims.**

*Specific Authority 624.308(1), 627.745(4) FS. Law Implemented 624.307(1), 626.171, 627.745 FS. History–New 3-14-93, Amended 8-6-98, 9-17-01, Formerly 4-176.022 Repealed_____.*

**69O-176.022 Mediation of Bodily Injury and Property Damage Claims.**

(1) Scope of Rule. This rule implements Section 627.745, Florida Statutes, and applies to any claim filed with an insurer for bodily injury in an amount of $10,000 or less or any claim for property damage in any amount, arising out of the ownership, operation, use, or maintenance of a motor vehicle when a party demands mediation before a lawsuit has been filed.

(2) Definitions. The following definitions shall apply for purposes of this rule:

(a) "Applicant" refers to the party demanding mediation of a claim prior to the institution of litigation.

(b) "Complete request for mediation" means that the applicant has demanded mediation by filing Form OIR-510 with a response to each query above the applicant's signature line and proper payment attached thereto for the amount specified on the Form, and the respondent has paid their share of the costs of mediation.

(c) "Office" means the Office of Insurance Regulation or its designee.

(d) "Natural person" means human being.

(e) "Respondent" means the party not initially requesting mediation.

(f) "Service office" means a designated office of the Bureau of Consumer Assistance, Division of Insurance Consumer Services, Department of Financial Services.

(3) Service Offices. For the purposes of designating mediators and for disposition of mediation conferences the State of Florida shall be divided among the following designated service offices:

(a) Daytona Beach Service Office shall be composed of the following counties: Flagler, Marion, Putnam, and Volusia.

(b) Fort Lauderdale Service Office shall be composed of Broward county.

(c) Fort Myers Service Office shall be composed of the following counties: Charlotte, Collier, DeSoto, Glades, Hendry, Highlands, and Lee.

(d) Jacksonville Service Office shall be composed of the following counties: Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Gilchrist, Hamilton, Lafayette, Levy, Nassau, St. Johns, Suwannee, and Union.

(e) Miami Service Office shall be composed of Dade and Monroe counties.

(f) Orlando Service Office shall be composed of the following counties: Brevard, Citrus, Lake, Orange, Osceola, Seminole, and Sumter.

(g) Pensacola Service Office shall be composed of the following counties: Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington.

(h) St. Petersburg Service Office shall be composed of the following counties: Manatee, Pinellas, and Sarasota.

(i) Tallahassee Bureau of Consumer Assistance Service Office shall be composed of the following counties: Gadsden, Franklin, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla.

(j) Tampa Service Office shall be composed of the following counties: Hardee, Hernando, Hillsborough, Pasco, and Polk.

(k) West Palm Beach Service Office shall be composed of the following counties: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie.

(4) Request for Mediation.

(a) An applicant demanding mediation shall file with the Office a request for mediation on Form OIR-510, "Request for Mediation," rev. 10/92, which is hereby adopted herein and incorporated by reference. This Form may be obtained from the Bureau of Consumer Assistance, Division of Insurance Consumer Services, Department of Financial Services, 200 East Gaines Street, Tallahassee, FL 32399-0300. A complete request for mediation shall be considered filed only when all costs of mediation are received by the Office. The Office shall notify the applicant in writing or by telephone if a filed request for mediation does not constitute a complete request for mediation. Notice shall occur within a reasonable period of time after receipt of the incomplete request for mediation.

(b) The costs of mediation shall be $100 per party. These costs shall be specified on Form OIR-510 and shall be disbursed to the Office.

(c) Upon receipt of a request for mediation, the Office shall issue an invoice to the respondent, specifying the respondent's share in the costs of mediation. The respondent shall make payment on or before the due date which shall be indicated on the invoice, unless the provisions of paragraph (e) are met. The due date shall be 20 days after the date of the invoice.

(d) All payments by the parties shall be made by certified check, money order, or insurance company check or draft.

(e) If a respondent objects to the mediation conference and refuses to participate, the respondent must, on or before the due date of the invoice, notify the Office in writing of their objection and refusal and specifically state the reasons therefor. These reasons

shall be deemed confidential and exempt from the provisions of Section 119.07(1), Florida Statutes, and shall not be publicly disclosed without the written consent of all parties to the dispute. Any research or evaluation effort directed at assessing program activities or performance shall protect the confidentiality of such information.

(5) Mediators.

(a) Appointment. The Bureau of Agent & Agency Licensing, Department of Financial Services, shall appoint as mediators those persons who meet the qualifications set forth in Section 627.745(3)(b), Florida Statutes. Persons wishing to be appointed as mediators shall submit their qualifications to the Bureau of Agent and Agency Licensing, Department of Financial Services, 200 East Gaines Street, Tallahassee, FL 32399-0300, on Form OIR-591, "Application for Appointment as a Mediator," rev. 1/93, which is hereby adopted and incorporated by reference.

(b) List of Appointed Mediators. The Bureau of Agent & Agency Licensing, Department of Financial Services, shall maintain a list of all appointed mediators, which list shall include the mediator's names, addresses, telephone numbers, social security numbers, date of entry to the list, and the counties in which the mediators are permitted to conduct mediation conferences. The Department shall assign a mediator number to each appointed mediator.

(c) Mediator Assignment To Service Offices. Mediators shall be assigned to the service offices serving the counties in which they are qualified and willing to mediate. The Department shall maintain a list of all appointed mediators assigned to each service office. Mediators shall be added to each service office list in the order in which they are appointed.

(d) Mediator Selection. Upon receipt of a complete request for mediation, the Department shall select a mediator from a list of mediators assigned to the appropriate service office. Upon the selection of a mediator, the Department shall notify the parties and the selected mediator in writing of the selection. Each party may once reject the selected mediator. Any rejection of a mediator must be in writing and received by the Department within 10 days of the date of the written notice of the mediator selection. If two mediators have been rejected, the third selected mediator may not be rejected. A mediator may refuse to conduct a particular mediation. If there are no mediators appointed or designated to conduct mediation conferences which correspond to the service office a mediator shall be designated as randomly determined by the Department.

(e) Grouping of Assignments. Requests for mediation received from applicants which correspond to a service office will, if feasible, be grouped together and assigned to a single mediator. A mediator will be assigned a maximum of four mediation conferences under a single assignment. Group mediation conferences shall be set in sequence by the Department at the service office.

(f) Procedure and Conduct. All mediation conferences shall be conducted in accordance with the Florida Rules for Certified and Court-Appointed Mediators, as set forth in rules 10.020-10.290, Florida Rules of Civil Procedure, and other consistent rules of conduct as promulgated by the Supreme Court of Florida. Mediators shall have the same responsibilities to the Department as they have to the courts under the Florida Rules for Certified and Court-Appointed Mediators. All mediators acting under this rule shall at all times conduct themselves in a professional manner consistent with the standards of their respective professions and the standards for mediators which may be adopted from time to time by the Supreme Court of Florida. The Florida Rules for Certified and Court-Appointed Mediators shall be read in a manner consistent with this rule and any conflict between this rule and the Florida Rules for Certified and Court-Appointed Mediators shall be resolved in favor of this rule. The mediator may communicate privately with the person representing either side of the dispute during a mediation.

(g) Complaints; Discipline. Complaints concerning a mediator shall be written and submitted to the Bureau of Consumer Assistance, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-0321. The Bureau of Consumer Assistance shall review all alleged instances of dishonest, incompetent, fraudulent, or unethical behavior on the part of a mediator and all instances in which the mediator allegedly failed to promptly and completely respond to proper requests from the Department and all instances in which the actions or failure to act on the part of the mediator violate this rule or standards set forth in this rule or are counter to the intent and purpose of this mediation program or this rule or Section 627.745, Florida Statutes. In such instances, the Department shall institute proceedings in accordance with Chapter 120, Florida Statutes, to revoke the appointment of any mediator whom the Bureau of Consumer Assistance finds has acted in a manner which shows that individual to be unsuited to be a mediator in this program.

(h) Invoice. Mediator shall bill the Department for their services associated with the automobile claim mediation conference by filing Form OIR-1121, (rev. 11/99) "Invoice", which is hereby adopted herein and incorporated by reference. This form may be obtained from the Bureau of Consumer Services Assistance, Division of Insurance Consumer Services, Department of Financial Services, 200 East Gaines Street, Tallahassee, FL 32399-0300.

(6) Mediation Conference.

(a) Location. If the applicant is a natural person, the mediation conference shall be held at the service office which corresponds to the applicant's county of residence. If the applicant is not a natural person, then the mediation conference shall be held at the service office which corresponds to the respondent's county of residence. If neither party is a natural person, then the mediation conference may be held at a location agreed to by the mediator and the parties. Before scheduling a mediation conference the mediator will contact the service office administrator to determine the availability of service office facilities to accommodate the mediation conference. If no facilities are available at the service office for the particular mediation conference then the service office administrator shall designate an alternative location for the mediation conference. If the parties determine that the assigned service office is inconvenient or impracticable, the parties and the mediator may agree to conduct the mediation conference at an alternative location. The mediator will notify the parties and the Department of the exact time, date, and location of the conference.

(b) Telephonic Mediation. Upon written consent of all parties, the mediation conference may be held by telephone if an in-person meeting of the parties and the mediator is inconvenient. The Department shall be advised in writing of the telephone mediation. The person or entity requesting that the mediation conference be held by telephone shall pay all telephone toll charges.

(c) Timing and Continuances. The mediation conference shall be held within 45 days after receipt by the Department of a complete request for mediation. Upon application by any party to the mediator for a continuance, the mediator shall, for good cause shown or if neither party objects, grant a continuance and shall notify all parties of the date and place of the rescheduled conference. If the applicant demonstrates to the mediator, on Form OIR-510, the need for an expedited mediation conference due to an undue hardship, the conference shall be conducted at the earliest date convenient to all of the parties and the mediator.

(d) Attendance. All natural persons who have an interest in the claim upon which the mediation conference is based shall attend the mediation conference and be fully authorized to make an agreement to completely resolve the claim. All corporate parties to the claim upon which the mediation conference is based shall attend the conference in the person of a corporate representative who has full knowledge of the facts of the claim and is fully authorized to make an agreement to completely resolve the claim.

(e) Good Faith Negotiation. All parties shall negotiate in good faith. By participating in the mediation process under these rules, the participants agree to negotiate in good faith to attempt to resolve the claim and agree to remain in the mediation conference until the claim is resolved or until the mediator declares an impasse. There is no requirement that the claim must be resolved in mediation.

(7) Disbursement of Funds. The funds paid by the parties shall be disbursed as follows:

(a) Completed Mediation Conference. If the mediation conference is held, 90% of the costs of mediation shall be disbursed to the mediator. The remaining 10% of the costs of mediation shall be deposited in the Insurance Commissioner's Regulatory Trust Fund.

(b) Cancellation. If a mediation conference is cancelled by a party for reason of settlement or for any other reason, the parties shall notify the mediator and the Department upon cancellation. If the mediation conference is not held due to cancellation, 70% of the individual party's paid costs of mediation shall be returned to the paid parties. Ten percent of the costs of mediation shall be deposited in the Insurance Commissioner's Regulatory Trust Fund. The mediator shall receive 20% of the costs of mediation.

(c) Cancellation Due To Absence. If a mediation conference is cancelled due to failure of a party to attend a conference, then the attending party shall be returned his paid share of the costs of mediation. The absent party will be refunded nothing. The mediator shall receive 80% of the remaining costs of mediation, and the remaining 20% of the costs of mediation shall be deposited in the Insurance Commissioner's Regulatory Trust Fund. Failure of a party to arrive at the mediation conference within 30 minutes of the conference's starting time shall be considered an absence.

(d) Rescheduling a Cancelled Mediation Conference. If a party wishes to mediate a claim after cancellation, the party must complete and file an original application with the Department as set forth above.

(e) Any disputes regarding the amount of disbursement of funds shall be resolved by the Department through its Chief, Bureau of Consumer Assistance, Division of Insurance Consumer Services.

(f) Any expenses associated with the mediation conference, such as travel, telephone, postage, meals, lodging, facilities, and other related expenses, shall be borne by the party, mediator or other person incurring the expense.

(g) The Department reserves the right to reduce fees based on consumer surveys and cost analysis.

(8) Post-Mediation.

(a) At the conclusion of the mediation conference, the mediator shall report to the Department the results of the mediation using the space provided on Form OIR-510. Failure of the mediator to promptly report shall be grounds for review of the mediator's appointment.

~~(b) Any demand for refund by a party to a mediation conference shall be filed in writing with the Department within 10 days of the last mediation conference at issue.~~

*Specific Authority 624.308(1), 627.745(4) FS. Law Implemented 624.307(1), 626.171, 627.745 FS. History–New 3-14-93, Amended 8-6-98, 9-17-01, Formerly 4-176.022.*

**69O-189.007 Insurer Experience Reporting - Excessive Profits, Workers' Compensation Insurance.**

*Specific Authority 624.308(1), 627.215 FS. Law Implemented 624.307(1), 624.424(1)(c), 627.215 FS. History–New 6-14-84, Amended 7-1-85, Formerly 4-59.061, Amended 6-1-88, Formerly 4-59.0061, Amended 12-20-00, Formerly 4-189.007, Amended 3-29-05 Repealed_____.*

~~**69O-189.007 Insurer Experience Reporting - Excessive Profits, Workers' Compensation Insurance.**~~

~~(1) Any insurer authorized to transact workers' compensation and employer's liability insurance in Florida shall report the data required by Section 627.215, F.S., by completing and submitting to the Office form OIR-B1-15 "Workers' Compensation Excessive Profits Reporting Form" in accordance with the instructions provided therein.~~

~~(2) Data submitted on form OIR-B1-15 is to be for Florida policyholders and shall be direct with respect to reinsurance.~~

~~(3) Form OIR-B1-15 is to be filed on or before July 1 of each year.~~

~~(4) Data shall be reported on a consistent basis from year to year. Any change in accounting or actuarial technique used in developing data shall be explained and justified.~~

~~(5) For the purposes of form OIR-B1-15, the following definitions shall apply:~~

~~(a) "Insurance group" shall mean one or more insurers operating under common management.~~

~~(b) "Policyholder dividends applicable to the calendar year" shall mean policyholder dividends incurred in a given calendar year, which is calculated as policyholder dividends paid plus reserve for policyholder dividends declared and unpaid at the end of the calendar year minus reserve for policyholder dividends declared and unpaid at the beginning of the calendar year. These reserves for policyholder dividends declared and unpaid shall only include those dividends officially declared by the insurer's board of directors and specifically identifiable as payable to Florida policyholders.~~

~~(c) "Cash" shall mean coins, currency, checks, drafts or money orders.~~

~~(6) Form OIR-B1-15 (rev. 1/01), Workers' Compensation Excessive Profits Reporting Form F is hereby incorporated by reference and may be obtained from the Office's web site at www.fldfs.com.~~

*Specific Authority 624.308(1), 627.215 FS. Law Implemented 624.307(1), 624.424(1)(c), 627.215 FS. History–New 6-14-84, Amended 7-1-85, Formerly 4-59.061, Amended 6-1-88, Formerly 4-59.0061, Amended 12-20-00, Formerly 4-189.007, Amended 3-29-05 Repealed _____.*

**69O-185.007 Insurer to Maintain and File Records.**

*Specific Authority 635.081 FS. Law Implemented 635.071(2) FS. History–Repromulgated 12-24-74, Amended 4-17-84, 4-30-86, Formerly 4-2.11, 4-2.011, 4-185.007 Repealed_____.*

~~**69O-185.007 Insurer to Maintain and File Records.**~~

~~Each mortgage guaranty insurer must maintain records as to insurance written in order that statistics may be accumulated by the Office, which statement of statistics must be filed semi-annually on or before September 1 and March 1 of each year, giving full and true information and statistics requested of mortgage guaranty insurance transacted as of June 30 and December 31 preceding the date of filing such statement, on Form OIR-13, "Mortgage Guaranty Insurance Reporting Form," giving information as to the premiums collected, underwriting expenses, loss experience, and any other information requested by the Office in order to carry out the provisions of Chapter 635, Florida Statutes. Form OIR-13, as amended, shall take effect on April 30, 1986 and may be obtained from the Office of Insurance Regulation, Bureau of Rates, Larson Building, Tallahassee, FL 32301.~~

*Specific Authority 635.081 FS. Law Implemented 635.071(2) FS. History–Repromulgated 12-24-74, Amended 4-17-84, 4-30-86, Formerly 4-2.11, 4-2.011, 4-185.007 Repealed_____.*

Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.215 Excessive profits for commercial property and commercial casualty insurance prohibited.—
(1)(a) Each insurer group writing commercial property insurance as defined in s. 627.0625, commercial umbrella liability insurance as defined in s. 627.0625, or commercial casualty insurance as defined in s. 627.0625 shall file with the office before July 1 of each year, on a form prescribed by the commission, the following data for the component types of such insurance as provided in the form:
1. Calendar-year earned premium.
2. Accident-year incurred losses and loss adjustment expenses.
3. The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.
4. Policyholder dividends applicable to the calendar year.

This paragraph does not prohibit an insurer from filing on a calendar-year basis.

(b) The data filed for the group shall be a consolidation of the data of the individual insurers of the group. However, an insurer may elect to consolidate commercial umbrella liability insurance data with commercial casualty insurance data or to separately file data for commercial umbrella liability insurance. Each insurer shall elect its method of filing commercial umbrella liability insurance at the time of filing data for accident year 1987 and shall thereafter continue filing under the same method. In the case of commercial umbrella liability insurance data reported separately, a separate excessive profits test shall be applied and the test period shall be 10 years.
(2)(a) Each insurer group writing commercial property insurance or commercial casualty insurance shall also file a schedule of Florida loss and loss adjustment experience for each of the 3 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of 3 evaluations will be provided for each accident year. For reporting purposes unrelated to determining excess profits, the loss and loss adjustment experience of each accident year shall continue to be reported until each accident year has been reported at eight stages of development.
(b) Each insurer group writing commercial umbrella liability insurance which elects to file separate data for such insurance shall also file a schedule of Florida loss and loss adjustment experience for each of the 10 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year, developed to an ultimate basis, and at nine 12-month intervals thereafter, each developed to an ultimate basis, so that a total of 10 evaluations will be provided for each accident year.
(3) Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: The sum of the accident-year incurred losses and loss adjustment expenses as of December 31 of the year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder

dividends applicable to the calendar year, shall be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.
(4) For the 3 most recent calendar-accident years for which data is to be filed under this section, the underwriting gain or loss shall be compared to the anticipated underwriting profit, except in the case of separately reported commercial umbrella liability insurance for which such comparison shall be made for the 10 most recent calendar-accident years.
(5)(a) Beginning with the July 1, 1991, report for commercial property insurance and commercial casualty insurance, an excessive profit has been realized if the net aggregate underwriting gain for these lines combined is greater than the net aggregate anticipated underwriting profit for these lines plus 5 percent of earned premiums for the 3 most recent calendar years for which data is to be filed under this section. For calculation purposes commercial property insurance and commercial casualty insurance shall be broken down into sublines in order to ascertain the anticipated underwriting profit factor versus the actual underwriting gain for the given subline.
(b) Beginning with the July 1, 1998, report for commercial umbrella liability insurance, if an insurer has elected to file data separately for such insurance, an excessive profit has been realized if the underwriting gain for such insurance is greater than the anticipated underwriting profit for such insurance plus 5 percent of earned premiums for the 10 most recent calendar years for which data is to be filed under this section.
(6) As used in this section with respect to any 3-year period, or with respect to any 10-year period in the case of commercial umbrella liability insurance, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated by Florida business, except that the anticipated underwriting profit for the purposes of this section shall be calculated using a profit and contingencies factor that is not less than zero. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.
(7) If the insurer group has realized an excessive profit, the office shall order a return of the excessive amounts after affording the insurer group an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded in all instances unless the insurer group affirmatively demonstrates to the office that the refund of the excessive amounts will render a member of the insurer group financially impaired or will render it insolvent under the provisions of the Florida Insurance Code.
(8) Any excess profit of an insurance company shall be returned to policyholders in the form of a cash refund or a credit toward the future purchase of insurance. The excessive amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the policyholders of record of the insurer group on December 31 of the final compilation year.
(9)(a) Cash refunds to policyholders may be rounded to the nearest dollar.
(b) Data in required reports to the office may be rounded to the nearest dollar.
(c) Rounding, if elected by the insurer, shall be applied consistently.
(10)(a) Refunds shall be completed in one of the following ways:
1. If the insurer group elects to make a cash refund, the refund shall be completed within 60 days after entry of a final order indicating that excessive profits have been realized.
2. If the insurer group elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order indicating that excessive profits have been realized. If an insurer group has made this election but an insured thereafter cancels her or his policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund within 60 days after termination of such coverage.

(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the office that the refunds have been made.
(11) Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year immediately succeeding the compilation period giving rise to the refund or credit, for purposes of reporting under this section for subsequent years.
(12) The application of this law to commercial property and commercial casualty insurance, which includes commercial umbrella liability insurance, ceases on January 1, 1997.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—

(1) (c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

635.081 Administration and enforcement.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter and shall have the same powers of administration and enforcement of the provisions of this chapter as it has with respect to casualty or surety insurers in general under the Florida Insurance Code.

635.071 Filings, approval of forms; rate filings.—

(2) Each insurer shall file with the office for informational purposes the rate to be charged and the premium to be paid by the policyholder, including all modifications of rates and premiums.

627.745 Mediation of claims.—
(1)(a) In any claim filed with an insurer for personal injury in an amount of $10,000 or less or any claim for property damage in any amount, arising out of the ownership, operation, use, or maintenance of a motor vehicle, either party may demand mediation of the claim prior to the institution of litigation.
(b) A request for mediation shall be filed with the department on a form approved by the department. The request for mediation shall state the reason for the request for mediation and the issues in dispute which are to be mediated. The filing of a request for mediation tolls the applicable time requirements for filing suit for a period of 60 days following the conclusion of the mediation process or the time prescribed in s. 95.11, whichever is later.
(c) The insurance policy must specify in detail the terms and conditions for mediation of a first-party claim.
(d) The mediation shall be conducted as an informal process in which formal rules of evidence and procedure need not be observed. Any party participating in a mediation must have the authority to make a binding decision. All parties must mediate in good faith.
(e) The department shall randomly select mediators. Each party may once reject the mediator selected, either originally or after the opposing side has exercised its option to reject a mediator.

(f) Costs of mediation shall be borne equally by both parties unless the mediator determines that one party has not mediated in good faith.
(g) Only one mediation may be requested for each claim, unless all parties agree to further mediation.
(2) Upon receipt of a request for mediation, the department shall refer the request to a mediator. The mediator shall notify the applicant and all interested parties, as identified by the applicant, and any other parties the mediator believes may have an interest in the mediation, of the date, time, and place of the mediation conference. The conference may be held by telephone, if feasible. The mediation conference shall be held within 45 days after the request for mediation.
(3)(a) The department shall approve mediators to conduct mediations pursuant to this section. All mediators must file an application under oath for approval as a mediator.
(b) To qualify for approval as a mediator, an individual must meet one of the following qualifications:
1. Possess an active certification as a Florida Supreme Court certified circuit court mediator. A Florida Supreme Court certified circuit court mediator in a lapsed, suspended, sanctioned, or decertified status is not eligible to participate in the mediation program.
2. Be an approved department mediator as of July 1, 2014, and have conducted at least one mediation on behalf of the department within 4 years immediately preceding that date.
(4) The department shall deny an application, or suspend or revoke its approval, of a mediator to serve in such capacity if the department finds that one or more of the following grounds exist:
(a) Lack of one or more of the qualifications specified in this section for approval.
(b) Material misstatement, misrepresentation, or fraud in obtaining or attempting to obtain the approval.
(c) Demonstrated lack of fitness or trustworthiness to act as a mediator.
(d) Fraudulent or dishonest practices in the conduct of mediation or in the conduct of business in the financial services industry.
(e) Violation of any provision of this code or of a lawful order or rule of the department, violation of the Florida Rules for Certified and Court-Appointed Mediators, or aiding, instructing, or encouraging another party in committing such a violation.

The department may adopt rules to administer this subsection.

(5) The department must adopt rules of procedure for claims mediation, taking into consideration a system which:
(a) Is fair.
(b) Promotes settlement.
(c) Avoids delay.
(d) Is nonadversarial.
(e) Uses a framework for modern mediating technique.
(f) Controls costs and expenses of mediation.
(6) Disclosures and information divulged in the mediation process are not admissible in any subsequent action or proceeding relating to the claim or to the cause of action giving rise to the claim. A person demanding mediation under this section may not demand or request mediation after a suit is filed relating to the same facts already mediated.

626.171 Application for license as an agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary.—
(1) The department may not issue a license as agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary to any person except upon written application filed with the department, meeting the qualifications for the

license applied for as determined by the department, and payment in advance of all applicable fees. The application must be made under the oath of the applicant and be signed by the applicant. An applicant may permit a third party to complete, submit, and sign an application on the applicant's behalf, but is responsible for ensuring that the information on the application is true and correct and is accountable for any misstatements or misrepresentations. The department shall accept the uniform application for nonresident agent licensing. The department may adopt revised versions of the uniform application by rule.

(2) In the application, the applicant shall set forth:

[1](a) His or her full name, age, social security number, residence address, business address, mailing address, contact telephone numbers, including a business telephone number, and e-mail address.

(b) A statement indicating the method the applicant used or is using to meet any required prelicensing education, knowledge, experience, or instructional requirements for the type of license applied for.

(c) Whether he or she has been refused or has voluntarily surrendered or has had suspended or revoked a license to solicit insurance by the department or by the supervising officials of any state.

(d) Whether any insurer or any managing general agent claims the applicant is indebted under any agency contract or otherwise and, if so, the name of the claimant, the nature of the claim, and the applicant's defense thereto, if any.

(e) Proof that the applicant meets the requirements for the type of license for which he or she is applying.

(f) The applicant's gender (male or female).

(g) The applicant's native language.

(h) The highest level of education achieved by the applicant.

(i) The applicant's race or ethnicity (African American, white, American Indian, Asian, Hispanic, or other).

(j) Such other or additional information as the department may deem proper to enable it to determine the character, experience, ability, and other qualifications of the applicant to hold himself or herself out to the public as an insurance representative.

However, the application must contain a statement that an applicant is not required to disclose his or her race or ethnicity, gender, or native language, that he or she will not be penalized for not doing so, and that the department will use this information exclusively for research and statistical purposes and to improve the quality and fairness of the examinations.

(3) Each application shall be accompanied by payment of any applicable fee.

(4) An applicant for a license as an agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary must submit a set of the individual applicant's fingerprints, or, if the applicant is not an individual, a set of the fingerprints of the sole proprietor, majority owner, partners, officers, and directors, to the department and must pay the fingerprint processing fee set forth in s. 624.501. Fingerprints shall be used to investigate the applicant's qualifications pursuant to s. 626.201. The fingerprints shall be taken by a law enforcement agency, designated examination center, or other department-approved entity. The department shall require all designated examination centers to have fingerprinting equipment and to take fingerprints from any applicant or prospective applicant who pays the applicable fee. The department may not approve an application for licensure as an agent, customer service representative, adjuster, service representative, managing general agent, or reinsurance intermediary if fingerprints have not been submitted.

(5) The application for license filing fee prescribed in s. 624.501 is not subject to refund.

(6) Members of the United States Armed Forces and their spouses, and veterans of the United States Armed Forces who have retired within 24 months before application for licensure, are exempt from the application filing fee prescribed in s. 624.501. Qualified individuals must provide a copy of a military identification card, military dependent identification card, military service record, military personnel file, veteran record, discharge paper, or separation document, or a separation document that indicates such members of the United States Armed Forces are currently in good standing or were honorably discharged.
(7) Pursuant to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, each party is required to provide his or her social security number in accordance with this section. Disclosure of social security numbers obtained through this requirement shall be limited to the purpose of administration of the Title IV-D program for child support enforcement.

627.913 Reports by products liability insurers.—The office may require any insurer authorized to write a policy of products liability insurance in the state to transmit the following information, based on its statewide products liability insurance writings. Upon the request of the office, an insurer shall, within 60 days, submit to the office a report that contains:
(1) Premiums written;

627.918 Reporting formats.—
(1) The office shall require that the reporting provided for in this part be made on forms established by the commission or in a format compatible with the office's electronic data processing equipment.

Florida Office of Insurance Regulation

Commissioner David Altmaier

# Quarterly Report

## Fiscal Year 2016-2017

## Second Quarter

Presented to:

# The Financial Services Commission

March 14, 2017

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Performance Measures — Second Quarter of Fiscal Year 2016-2017

Activities & Developments — Market Updates and Office Activities

Florida Office of Insurance Regulation

# Performance Measures
## Second Quarter Fiscal Year 2016-2017 (October – December)

| | Office Performance Measures | 2nd Quarter FY 2016-2017 | | 1st Quarter FY 2016-2017 | |
|---|---|---|---|---|---|
| | Objective | Result | Score | Result | Score |
| 1 | Applications for a new certificate of authority and new types of insurance added to an existing certificate of authority within 90 days | *100%* | 5 | *100%* | 5 |
| 2 | Life and health form and rate filing reviews completed within 45 days | *100%* | 5 | *100%* | 5 |
| 3 | Property and casualty form filing reviews completed within 45 days | *100%* | 5 | *98.9%* | 5 |
| 4 | Property and casualty rate filing reviews completed within 90 days | *98.7%* | 5 | *100%* | 5 |
| 5 | Market conduct exams with violations in which the Office requires companies to remediate | *100%* | 5 | *100%* | 5 |
| 6 | Financial exams of domestic insurers completed within 18 months of the "as of" exam date | - | * | - | * |
| 7 | Life and health priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date | - | * | - | * |
| 8 | Property and casualty priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date | - | * | - | * |
| 9 | Priority financial analyses completed within 60 days | *100%* | 5 | *99.4%* | 4 |
| 10 | Non-priority financial analyses completed within 90 days | *99.9%* | 4 | *99.6%* | 4 |
| | Overall Score | | 4.86 | | 4.71 |

*Note: Scoring is based on the scale adopted by the Financial Services Commission, with 1 being lowest and 5 being highest, and each measure of equal weight.*

**Financial examinations are generally cyclical over long-periods of time and, while several are currently in progress, none were due in the first two quarters.*

# 2016 Hurricane Season Update

## Hurricane Hermine

Reporting as of March 3, 2017

- 19,699 statewide claims reported
- $139 million in estimated insured losses
- 92.9% of claims closed

## Hurricane Matthew

Reporting as of March 3, 2017

- 119,345 statewide claims reported
- $1.18 billion in estimated insured losses
- 90.5% of claims closed

*The Office has developed an interactive Excel workbook where Florida consumers and stakeholders can download and view claims on the county level and by various lines of business. Visit www.floir.com and select "Hurricane Claims Data"

# Selected Activities & Developments – Property & Casualty

## 2016 Medical Malpractice Annual Report:

- Florida is the fourth largest U.S. state in terms of medical malpractice premium, with roughly $530 million in 2015 direct written premium
- Among the top 10 states by premium, Florida's:
  - Combined loss and defense and cost containment ratio of 67.8% ranks fourth highest
  - Non-claims based expense ratio of 21.8% is the highest among the top 10 states
  - Claims-based adjusting and other expense of 4.9% ranks third highest among the top 10 states
  - Combined ratio (total payouts to premium) of 101.1%, up from 96.6% in 2014, is the third largest
- The average rate change for a Florida physician as a result of rate filings resolved in 2015 was a decrease of 1.7%

## 2016 Workers' Compensation Report:

- Florida's workers' compensation insurance market exhibits a reasonable degree of competition
- No significant barriers for entry and exit exists in the Florida market
- The residual market is small relative to the private market indicating the voluntary market offers reasonable availability
- There may be some small segments of the market which have difficulty obtaining workers' compensation insurance, including small firms and new firms
- Recent **Florida Supreme Court** cases relating to workers' compensation continues to create **uncertainty** in the marketplace going forward.

# Selected Activities & Developments – Life & Health

## Long-Term Care:

- Developed an ambitious and innovative approach to help reduce the impact of rising long-term care premiums:
  - Extended rate guarantees
  - Multi-year phase-in of rate increases
  - Rate increase alternatives (e.g. flexible benefit periods and reduced inflation coverage)
  - Lapse protection
- Working towards creating more consumer choice in the long-term care market by reducing obstacles to product innovation

## Life Insurer Solvency:

- The Office is working toward smooth implementation of SB 1308, which modernized life insurer solvency regulation and became effective on 1/1/2017

## Freedom to Travel Report:

- No consumer complaints were received by either the Office or Consumer Services related to foreign travel
- There were only 3 reported violations and, in all cases, the companies self-corrected the violations prior to the report being issued

## Legislative Agenda

- Assignment of Benefits (AOB)
  - The bill focuses on holding consumers harmless, allowing them to continue utilizing an assignment of benefits when they need it, and eliminating incentives for filing unnecessary litigation
- Continuing Care Retirement Communities (CCRC)
  - Working to protect Florida seniors by strengthening the financial condition of CCRCs and developing tools to prevent inequitable activity
- Insurer Solvency
  - Modernizing HMO solvency regulation through the use of Risk Based Capital (RBC)
  - Expand the Guaranty Association assessment base such that when covering a long-term care insolvency liability, companies who wrote long-term care are assessed first.

# Questions?