



# Market Conduct Report of Rescinded Policies

## Florida Office of Insurance Regulation

Pursuant to Section 627.728, Florida Statutes

This template is provided for reporting Private Passenger polices that have been rescinded by authorized Florida Insurance carriers.

**DEADLINE FOR COMPLETING AND SUBMITTING THIS DATA FILING IS WITHIN 90 DAYS OF A POLICY RESCISSION.**

Data must be submitted on an individual company basis only.

The Insurance Regulation Filing System (IRFS) application located at <https://irfs.fldfs.com/> is required to be used to submit your data.

### COMPONENTS OF THE FILING

Your Market Conduct Report of Rescinded Policies (MCRP) Data Filing will include the following components:

- Reporting Template – This is an Excel file. It is downloaded from within IRFS. You will click on “+” to upload successfully.
- Contacts – Filers can add other individuals to received correspondence on this filing. Save once all individuals have been included.
- Other Information/Documents – Upload any information in the available formats needed to explain any data or other portion of the filing.
- The “Response to Request for Clarification” component should be used only as a response area after submission; upload documents to this component should the Office request additional information to complete your filing.

Please note: Additional underlying documentation shall be made available upon request of the Office.

If you have any questions regarding IRFS support, please contact the Market Research and Technology Unit at 850-413-3147, or by email:

[MCRP@fลอ.ร.com](mailto:MCRP@fลอ.ร.com)

## **General Instructions**

- Expand components by clicking on the plus sign.
- Select the Florida MCRP Template. This is a mandatory component. Follow the instructions to download the Excel template file to your local PC. Save the template to your local drive – you may add to it as needed and upload it back to the same page in IRFS when you are ready (just as long as you are reporting all policies within 90 days of rescission).

### **Steps for completing the template:**

- Open the Contacts page and verify the information displayed.
  1. Enter the submission date on the top line when you are ready to submit.
  2. Complete any other responses that are not present or in need of correction so that all data validations on the right-hand are “TRUE”.
- Policy information is entered on the Policy tab. Complete the columns as shown:
  1. Policy Holder’s Name
  2. Policy Number (Enter a Single Policy Per Row)
  3. Date of Application for Coverage Policy (Policy Effective Date)
  4. Date of Rescission of this Policy (Date of Decision to Rescind This Policy)
  5. Has a Claim Been Filed on This Policy? (Yes or No)
  6. If “No”, then the data validation value of “True” will appear on the right-hand side meaning the row is complete.
  7. If “Yes”, then you must enter the Claim Number and Date of Claim in the last two columns. Note that four rows per policy are provided for multiple claims.

The policy holder tab is made available to allow manual printing of the OIR-B3-493 Form. Instructions are on this tab. Requests are entered on this tab and affect the output on the OIR-B3-493 tab, which is the Print tab (i.e., after requesting a form be created, skip to this tab, and print the page). This process may be repeated for any of the 50 lines of the Policy tab by clearing the yellow block on the Policyholder tab and clicking <Enter>. This process is for the benefit of the filer. These forms do not need to be emailed or delivered in any form to the Office.

### **Documentation, either electronically stored or otherwise, should be maintained by the filer.**

- In the Contacts Component, other email accounts subscribed to your company will be listed under Add Company Contact. Include additional email addresses that are not subscribers of the company in the text box. Any email listed in this component will receive email notifications about the filing. Click Save.

- There is an optional Other Information/Documents component if you choose to include a letter or upload relevant documents.
- There is an optional Response to Request for Clarification component that may be ignored during the initial filing. This is for use only if OIR has questions after reviewing your filing.
- When all mandatory components are Complete, your filing may be submitted by clicking on the Submit button.
- You and any accounts listed in Company Contacts will receive an email receipt with your Filing ID. If you do not receive an email and the submission status does not change to Received, contact the Market Research and Technology Unit.

If you have any questions, please contact the Market Research and Technology Unit Section via email: [MCRP@flore.com](mailto:MCRP@flore.com) or telephone 850-413-3147.

**THE MCRP TEMPLATE FORMAT IS SHOWN ON THE FOLLOWING PAGES**

## MCRP Template Contacts Tab

Except for the Submission Date, the below information is usually pre-populated from the user's account information.

### Contact Information

**THIS IS REQUIRED INFORMATION** that is to be provided each time

*Be sure to verify the cells we have pre-filled - they must be accurate!*

		VALIDATION CHECKS	Required Data
			Field Complete?
1	Enter Submission Date	1/19/2018	TRUE
2	Please provide the name of the individual responsible for the coordination and submission of this requested information		FALSE
3	What is her or his email address?		FALSE
4	What is the best number where she or he can be reached?		FALSE
5	What is the Company's Name? (Group filings not allowed)		FALSE
6	What is the Company's NAIC Code? ("00000" if no NAIC Code exists)		FALSE
7	What is the Florida Company Code?		FALSE
8	What is the Company's FEIN?		FALSE
10	Count of rows with validation errors on "Policy" tab:	NONE	TRUE

## MCRP Template Policy Tab

A line number request placed on the Policyholder tab will generate the printable OIR-B3-493 form using Policy tab information.

Section B - Policy Information												
THIS IS REQUIRED INFORMATION that is to be provided each time the data template is submitted to the Office of Insurance Regulation.												
Line No.	POLICY TYPE (Exact Alphabetic Description)	POLICY HOLDER'S NAME	POLICY NUMBER (Enter a Single Policy Per Row)	DATE OF APPLICATION FOR COVERAGE (Policy Effective Date)	DATE OF RESCISSION OF THIS POLICY (Date of Decision to Rescind This)	HAS A CLAIM BEEN FILED ON THIS POLICY? (Yes or No)	Sequence ID Number (HIDDEN COLUMN)	CLAIM REF.	CLAIM NUMBER (One Per Row; Up to Four Per Policy)	DATE OF CLAIM (Must Correspond to Claim Number on Row)	VALIDATION CHECK	ROWS WITH ERRORS:
1							10001	A			TRUE	
							10002	B			TRUE	
							10003	C			TRUE	
							10004	D			TRUE	
2							10005	A			TRUE	
							10006	B			TRUE	
							10007	C			TRUE	
							10008	D			TRUE	
3							10009	A			TRUE	
							10010	B			TRUE	
							10011	C			TRUE	
							10012	D			TRUE	
4							10013	A			TRUE	
							10014	B			TRUE	
							10015	C			TRUE	
							10016	D			TRUE	
5							10017	A			TRUE	
							10018	B			TRUE	
							10019	C			TRUE	
							10020	D			TRUE	

The above format continues for 50 Policy lines, 4 Claims lines per Policy.

## **MCRP Template Policyholder Tab**

Use this tab to request a printable OIR-B3-493 form. Maintenance of this form is optional and intended for the filer's records only.

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### **Policyholder Information**

**The purpose of this tab is to generate the OIR-B3-493 form on the next tab**

Should a printed version of the OIR-B3-493 be required, enter the Line Number then press <Enter>

**ENTER LINE NUMBER FROM POLICY TAB (Column F)**

*After ordering a report, go to the OIR-B3-493 tab and print the page;  
You may clear the block above and re-enter other Line Numbers for additional reports*

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## MCRP Template OIR-B3-493 Tab

A line number request placed on the Policyholder tab will generated the printable OIR-B3-493 form using Policy tab information.

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**FLORIDA OFFICE OF INSURANCE REGULATION**  
**REPORT OF RESCINDED POLICY**

RETURN THIS COMPLETED FORM TO:

OFFICE OF INSURANCE REGULATION  
MARKET INVESTIGATIONS UNIT  
ROOM 220, LARSON BUILDING  
TALLAHASSEE, FL 32399-4210

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:

CLAIM NO \_\_\_\_\_      DATE \_\_\_\_\_  
CLAIM NO \_\_\_\_\_      DATE \_\_\_\_\_  
CLAIM NO \_\_\_\_\_      DATE \_\_\_\_\_  
CLAIM NO \_\_\_\_\_      DATE \_\_\_\_\_

DATE OF RESCISSION OF THIS POLICY \_\_\_\_\_

**THE FOLLOWING MUST BE RETAINED FOR THREE (3) CALENDAR EARS 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

Form OIR-B3-493  
Rev. 7/2006