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

March 12, 2019

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

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

8:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for December 4, 2018.

   http://www.myflorida.com/myflorida/cabinet/agenda18/1204/OIR120418.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Rules 69O-149.005, .006; Reasonableness of Benefits in Relation to Premiums; Actuarial Memorandum

   Rule 69O-149.005 is amended to allow the types of insurance referenced in subsection (15) to be exempt from the requirements of paragraph 14(b). Rule 69O-149.006 is amended to update the Experience on the Form requirements in subparagraph (3)(b)23. and the actuarial certification requirements in subparagraph (3)(b)28.

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Rule 69O-154.202; Definitions

   Rule 69O-154.202 is amended to update the definition of Commonly Accepted Actuarial Practice.

   (ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Rules 69O-163.009,.011; Determination of Reasonableness of Benefits in Relation to Premium Charge; Credit Disability Insurance Rates

   Rule 69O-163.009 is amended to require the filing of Form OIR-B2-2213 to provide numerical and written justification when there is a deviation from prima facie rates. The maximum credit disability insurance premium rates are amended in Rule 69-163.011.

(ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

5. Request for Approval for Publication of Rules 69O-191.074,.076,.078; Records Retention; Corrective Action Plans; Subscriber Grievance Procedure

   Rule 69O-191.074 is amended to update and delete out of date references to government agencies and update the manner to retain records. Rule 69O-191.076 is amended to incorporate a form for filing a pro forma projection of an anticipated program. Rule 69O-191.078 is amended to delete references to the Statewide Subscriber Assistance Panel due to the repeal of section 408.7056, F.S.

(ATTACHMENT 5) **APPROVAL FOR PUBLICATION**

6. Request for Approval for Final Adoption of Rules 69O-203.204,.205; Filing Approval of DMPO Plans, Rates and Related Forms; Bundled Products

   The rules are being repealed to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida. These rules are obsolete.

(ATTACHMENT 6) **APPROVAL FOR FINAL ADOPTION**

7. Request for Approval for Final Adoption of Rules 69O-203.201,.202,.203,.210; Definitions; Standards for Discount Medical Plans; Standards for the Form and Content of Advertisements or Marketing Materials; Forms Incorporated by Reference

   The rules will be updated to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida, renaming “discount medical plan organizations” to “discount plan organizations” and revising conditions for reimbursement, disclosure requirements, reporting requirements, fee requirements, marketing requirements, and the authority for the Financial Services Commission to adopt rules.

(ATTACHMENT 7) **APPROVAL FOR FINAL ADOPTION**

8. Request for Final Adoption of Rules 69O-238.001,.002; Application; Change in Information

   The Office of Insurance Regulation is developing new rules to implement Ch. 2018-91, Laws of Florida, signed into law on March 23, 2018. The legislation requires the Financial Services Commission to implement some of its provisions by rule.

(ATTACHMENT 8) **APPROVAL FOR FINAL ADOPTION**

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

   The amendments incorporate by reference new editions of the NAIC’s Annual Statement Instructions, the NAIC’s Quarterly Statement Instructions, and the NAIC’s Accounting Practices and Procedures Manual.

(ATTACHMENT 9) **APPROVAL FOR FINAL ADOPTION**

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

    The amendments incorporate by reference new editions of the NAIC Financial Condition Examiners Handbooks.

    (ATTACHMENT 10) **APPROVAL FOR FINAL ADOPTION**

11. Office of Insurance Regulation Second Quarter Report FY 2018-2019

    (ATTACHMENT 11) **FOR APPROVAL**

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Approval to Publish Amendments to
Rules 69O-149.005,.006
Assignment # 214277-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request to approve for publication the proposed rules.

Rule 69O-149.005 is amended to allow the types of insurance referenced in subsection (15) to be exempt from the requirements of paragraph 14(b). Rule 69O-149.006 is amended to update the Experience on the Form requirements in subparagraph (3)(b)23. and the actual certification requirements in subparagraph (3)(b)28.

Sections 624.308(1), 626.9541(1), 627.410(1), (2), (6), 627.410(7), 627.411(1)(a), (e), 627.9175 F.S., are the rulemaking authority and laws implemented for these rules.

Michael Lawrence, Jr., 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-149.005 Reasonableness of Benefits in Relation to Premiums.

(1) through (13) No change.

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

(a) The coverage is for annually rated group health insurance policies for which filing of rates is exempted by section 627.410(6), F.S., and excluding disability income policies:

(b) The provision may not apply for greater than 24 months unless otherwise exempted by the Office ;

(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 benefit 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 insurer 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.

(15) Accident only, accidental death and dismemberment, dental, hearing, hospital indemnity, hospital/surgical medical expense, intensive care, and vision plans issued by an insurer are exempt from the requirement of paragraph (14)(b). This provision may not apply for greater than 60 months for dental and vision plans issued by an insurer.

Rulemaking Authority 624.308(1), 627.410(6)(b), (d), (e) FS. Law Implemented 626.9541(1), 627.410(6)(d), (e), 627.410(7), 627.411(1)(a), (e), 627.9175 FS. History–New 7-1-85, Formerly 4-58.05, 4-58.005, Amended 4-18-94, 11-20-02, Formerly 4-149.005, Amended 5-18-04, 11-2-06, 6-18-07, 10-1-08, _____.

69O-149.006 Actuarial Memorandum.

(1) and (2) No change.

(3) Descriptions.

(a) No change.

(b) The descriptions, by item number, of the terms listed above in subsection (2), follow:

1. through 22. No change.

23. Experience on the Form (Past and Future Anticipated): This section shall display the actual experience on the form and that expected for the future.

a. Past Experience: Experience from inception (or the last 3 years for annually rated group coverages) shall be displayed, although, with proper interest adjustment, the experience for calendar years more than 10 years in the past may be combined. Excluding annually rated group policy forms, earned premiums, actual incurred and expected claims experience shall also be displayed, for each policy year or issue year, within the calendar year. The following information shall be displayed (A sample experience exhibit is illustrated in Appendix A, Illustrative Experience Exhibit (2/04), which is hereby incorporated by reference):

(I) and (II) No change.

(III) Claims incurred and paid, ~~Paid claims,~~ for past periods only;

(IV) Remaining claim liability and reserve, ~~Change in claim liability and reserve,~~ for past periods only. These reserves shall be updated to reflect actual claim runoff as it develops;

(V) through (XI) No change.

b. Future periods where the projected values are based on inforce experience:

(I) through (VI) No change.

(VII) Two projections will be required to be submitted to the Office. Projections shall be based on existing inforce business with and without ~~no~~ new sales assumed during the projection period.

(VIII) No change.

c. Projections for new forms or otherwise not based on experience shall:

(I) Two projections will be required to be submitted to the Office. Project an initial assumed cohort of new business with and without ~~no~~ new sales assumed during the projection period; and,

(II) No change.

d. No change.

24. through 27. No change.

28. Actuarial Certification:

a. Certification by a qualified actuary that to the best of the actuary's knowledge and judgment:

(I) No change.

(II) Complies with the Commonly Accepted Actuarial Practice as defined in subsection 69O-154.202(28), F.A.C. ~~all applicable Actuarial Standards of Practice~~; and,

(III) No change.

b. In making the certification:

(I) No change.

(II) The actuary's opinion shall comply with the Commonly Accepted Actuarial Practice as defined in subsection 69O-154.202(28), F.A.C. ~~The applicable Actuarial Standards of Practice, incorporated in subsection 69O-154.202(27), F.A.C., are as provided in the Applicability Guidelines for Actuarial Standards of Practice, second edition, as developed by the Council on Professionalism of the American Academy of Actuaries, August 1999, which standard is hereby adopted and incorporated by reference.~~

~~c. A copy of the Applicability Guidelines for Actuarial Standards of Practice may be obtained from the Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0328.~~

c.~~d.~~ A qualified actuary is one who is a member of the Society of Actuaries or the American Academy of Actuaries, and who is qualified in the area of health insurance.

d.~~e.~~ If the actuary is unable to provide the certification without qualification, a detailed explanation and reason for the qualification shall be provided as part of the certification.

Rulemaking Authority 624.308(1), 627.410(6)(b), (e) FS. Law Implemented 627.410(1), (2), (6), 627.411(1)(e) FS. History–New 7-1-85, Formerly 4-58.06, 4-58.006, Amended 4-18-94, 4-9-95, 11-20-02, 6-19-03, Formerly 4-149.006, Amended 5-18-04, 11-2-06, 10-1-08, _____.

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Approval to Publish Amendments to
Rule 69O-154.002
Assignment # 217496-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request to approve for publication the proposed rules.

Rule 69O-154.202 is being amended to update the definition of Commonly Accepted Actuarial Practice.

Sections 624.308(1), 624.307(1), 625.081, 625.121, F.S., are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr., 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-154.202 Definitions.

As used in this rule chapter, the following terms have the following meaning:

(1) through (27) No change.

(28) Commonly Accepted Actuarial Practice. Practices consistent with standards of practice established by the Actuarial Standards Board. ~~as of December 31, 2002 as embodied in "Actuarial Standards of Practice" which are hereby incorporated herein by reference.~~

(29) through (33) No change.

Rulemaking Authority 624.308(1), 625.121(14), 625.081 FS. Law Implemented 624.307(1), 625.081, 625.121 FS. History–New 4-14-99, Formerly 4-154.202, Amended 3-1-04, 1-25-16.

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Approval to Publish Amendments to
Rule 69O-163.009,.011
Assignment # 207469-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request to approve for publication the proposed rules.

The amendment to Rule 69O-163.009, FAC, specifies the credibility factors to be applied for the calculation of deviations from prima facie rates. The amendments to Rule 69O-163.011, FAC, amend the maximum credit disability insurance premium rates.

Sections 624.308(1), 627.678, 624.307(1), 627.6785, 627.682, FS, are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr., 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-163.009 Determination of Reasonableness of Benefits in Relation to Premium Charge.

(1) through (5) No change.

(6) Any deviation from prima facie rates shall require numerical and written justification. The numerical information shall be displayed as illustrated in Form OIR-B2-2213, Appendix A, Illustrative Experience Exhibit, effective 10/18, hereby incorporated by reference and available at www.flrules.org/XXXXX, and submitted electronically via the Office's Filing Assembly Submission System (FASS) at https://iportal.fldfs.com/ifile/fass/default.asp.

Rulemaking Authority 624.308(1), 627.678 FS. Law Implemented 624.307(1), 627.678, 627.682 FS. History–New 5-9-82, Formerly 4-7.09, Amended 6-11-91, Formerly 4-7.009, Amended 3-15-94, 2-11-03, Formerly 4-163.009, Amended 9-30-09, Amended_____.

69O-163.011 Credit Disability Insurance Rates.

(1) Credit disability insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall not be greater than in paragraphs (a) and (b). Paragraphs (c), (d) and (e) refer to premium rates for other types of coverages either alone or in combination with the type of coverages applicable to paragraphs (a) and (b).

(a) If premiums are payable on a single-premium basis for the duration of the coverage:

TABLE I

No. of months in which indebtedness is repayable	14-Day Non-Retroactive	30-Day Non-Retroactive	7-Day Retroactive	14-Day Retroactive	30-Day Retroactive
6 or less	$0.65 ~~$0.81~~	$0.29 ~~$0.36~~	$1.18 ~~$1.47~~	$1.04 ~~$1.30~~	$0.84 ~~$1.05~~
7-12	0.90 ~~1.13~~	0.58 ~~0.72~~	1.41 ~~1.76~~	1.26 ~~1.58~~	1.09 ~~1.36~~
13-18	1.17 ~~1.46~~	0.86 ~~1.08~~	1.64 ~~2.05~~	1.50 ~~1.87~~	1.34 ~~1.67~~
19-24	1.42 ~~1.78~~	1.15 ~~1.44~~	1.87 ~~2.34~~	1.73 ~~2.16~~	1.58 ~~1.97~~
25-30	1.69 ~~2.11~~	1.44 ~~1.80~~	2.11 ~~2.64~~	1.96 ~~2.45~~	1.82 ~~2.28~~
31-36	1.94 ~~2.43~~	1.73 ~~2.16~~	2.34 ~~2.93~~	2.19 ~~2.74~~	2.06 ~~2.58~~
37-48	2.27 ~~2.84~~	2.16 ~~2.70~~	2.67 ~~3.34~~	2.48 ~~3.10~~	2.38 ~~2.97~~
49-60	2.53 ~~3.16~~	2.38 ~~2.97~~	2.95 ~~3.69~~	2.70 ~~3.38~~	2.62 ~~3.28~~
61-72*	2.74 ~~3.43~~	2.62 ~~3.27~~	3.18 ~~3.97~~	2.90 ~~3.62~~	2.82 ~~3.53~~
73-84*	2.89 ~~3.61~~	2.78 ~~3.47~~	3.34 ~~4.18~~	3.03 ~~3.79~~	2.96 ~~3.70~~
85-96*	3.01 ~~3.76~~	2.91 ~~3.64~~	3.47 ~~4.34~~	3.14 ~~3.92~~	3.07 ~~3.84~~
97-108*	3.09 ~~3.86~~	3.00 ~~3.75~~	3.57 ~~4.46~~	3.21 ~~4.01~~	3.15 ~~3.94~~
109-120*	3.16 ~~3.95~~	3.08 ~~3.85~~	3.64 ~~4.55~~	3.27 ~~4.09~~	3.22 ~~4.02~~
Per month for terms exceeding 120 months	.0242 ~~.0303~~	.0237 ~~.0296~~	.0278 ~~.0348~~	.0246 ~~.0313~~	.0246 ~~.0308~~

(b) through (f) No Change.

(2) No change.

Rulemaking Authority 624.308(1), 627.678 FS. Law Implemented 624.307(1), 627.678, 627.6785, 627.682 FS. History–New 5-9-82, Formerly 4-7.11, Amended 6-11-91, Formerly 4-7.011, Amended 2-11-03, Formerly 4-163.011, Amended 9-30-09, Amended_____.

Form OIR-B1-2213
Appendix A, Illustrative Experience Exhibit
Effective 10/18
Incorporated by Reference in
Rules 69O-149.006 and 69O-163.009, F.A.C.

Projection Assumptions:

Rate Increase effective 07/01/2016	19.2%
Claim Trend	15.0%
Insurance Trend	1.0%
Lapse Rate	20.0%
Aging	1.00

Future premium increases equal claim trend

	Cal Year	Earned Premium	Paid Claims	Remaining Claim Liability & Reserve	Incurred Claims	Incurred Loss Ratio	Expected Incurred Claims *	Expected Loss Ratio *	A/E Claims Ratio	Active Life Reserves	Earned Premium Manual Rate Basis	Earned Premium Current Rate Basis	Past Rate Increases	
		(a)	(b)	(c)	(d)	(e) = (c) + (d)	(f) = (e) / (b)	(g)	(h)	(i)	(j)	(k)	(l)		
	2008	565,464	207,477	-	207,477	36.7%	209,222	37.0%	99.2%	-	565,464.00	715,312		
	2009	1,337,824	575,693	-	575,693	43.0%	561,946	42.0%	102.4%	-	1,337,824.20	1,692,348		
	2010	2,352,416	927,487	-	927,487	39.4%	1,075,107	45.7%	86.3%	-	2,352,416.18	2,975,806		
	2011	3,986,382	1,749,723	-	1,749,723	43.9%	1,896,723	47.6%	92.2%	-	3,986,381.86	5,042,773		
	2012	5,339,093	2,211,239	1,106	2,212,344	41.4%	2,696,178	50.5%	82.1%	-	5,339,092.79	6,753,952		
	2013	6,174,297	3,544,650	31,446	3,576,096	57.9%	3,308,434	53.6%	108.1%	-	6,174,296.66	7,810,485		
	2014	6,959,921	3,818,031	375,902	4,193,933	60.3%	3,974,882	57.1%	105.5%	-	6,959,920.78	8,394,570	10.0%	7/1/09
	2015	8,259,585	3,537,263	1,834,316	5,371,578	65.0%	4,812,170	58.3%	111.6%	-	8,259,584.83	8,857,418	15.0%	7/1/10
	2016	7,747,260			5,474,303	70.7%	5,392,577	69.6%	101.6%	-				
	2017	7,246,233			5,657,119	78.1%	5,665,512	78.2%	99.9%	-				
	2018	6,666,534			5,588,695	83.8%	5,596,987	84.0%	99.9%	-				
	2019	6,133,212			5,332,842	87.0%	5,340,754	87.1%	99.9%	-				
	2020	5,642,555			4,991,619	88.5%	4,999,025	88.6%	99.9%	-				
	2021	5,191,150			4,638,212	89.3%	4,645,094	89.5%	99.9%	-				
	2022	4,775,858			4,309,827	90.2%	4,316,221	90.4%	99.9%	-				
	2023	4,393,790			4,004,691	91.1%	4,010,633	91.3%	99.9%	-				
	2024	4,042,286			3,721,159	92.1%	3,726,680	92.2%	99.9%	-				
	2025	3,718,903			3,457,701	93.0%	3,462,831	93.1%	99.9%	-				
	2026	3,421,391			3,212,896	93.9%	3,217,663	94.0%	99.9%	-				
	2027	3,147,680			2,985,423	94.8%	2,989,852	95.0%	99.9%	-				
	2028	2,895,866			2,774,055	95.8%	2,778,171	95.9%	99.9%	-				
	2029	2,664,196			2,577,652	96.8%	2,581,476	96.9%	99.9%	-				
	2030	2,451,061			2,395,154	97.7%	2,398,708	97.9%	99.9%	-				
	2031	2,254,976			2,225,577	98.7%	2,228,879	98.8%	99.9%	-				
	2032	2,074,578			2,068,006	99.7%	2,071,074	99.8%	99.9%	-				
	2033	1,908,611			1,921,591	100.7%	1,924,442	100.8%	99.9%	-				
	2034	1,755,923			1,785,543	101.7%	1,788,192	101.8%	99.9%	-				
	2035	1,615,449			1,659,126	102.7%	1,661,588	102.9%	99.9%	-				
	2036	1,486,213			1,541,660	103.7%	1,543,947	103.9%	99.9%	-				
	2037	1,367,316			1,432,511	104.8%	1,434,636	104.9%	99.9%	-				
	2038	1,257,931			1,331,089	105.8%	1,333,064	106.0%	99.9%	-				
	2039	1,157,296			1,236,848	106.9%	1,238,683	107.0%	99.9%	-				
	2040	1,064,712			1,149,279	107.9%	1,150,984	108.1%	99.9%	-				
Past		34,974,981			18,814,331	53.8%	18,534,661	53.0%	101.5%	-	34,974,981	42,242,665		
Future		86,080,978			77,472,577	90.0%	77,497,673	90.0%	100.0%	-				
Lifetime		121,055,960			96,286,908	79.5%	96,032,334	79.3%	100.3%	-				
Interest	5.0%													
Past		39,954,527			21,162,901	53.0%	20,985,327	52.5%	100.8%	-	39,954,527	48,471,391		
Future		59,677,447			52,202,547	87.5%	52,192,316	87.5%	100.0%	-				
Lifetime		99,631,974			73,365,448	73.6%	73,177,643	73.4%	100.3%	-				

Each filing should include an exhibit with the requested increase and one without the requested increase.
Formulas (and underlying assumptions) used to determine projected values should be disclosed as part of the filing.
Assumptions disclosed should include the interest, medical trend, insurance trend, aging, lapse, shock lapse, and the effectiveness of past and proposed rate increases.

** Calendar year expected claims and expected loss ratios are taken from the durational experience exhibit. 2011 expected loss ratios are taken from the approved durational loss ratio slope one duration beyond the 2010 expected loss ratio. Each additional future value follows the approved durational loss ratio slope.*

Appendix A, Continued

Premium By Duration and Calendar Year

Ann Dur	2008	2009	2010	2011	2012	2013	2014	2015	Total
1	565,464	885,453	1,325,465	2,154,657	2,365,453	2,265,752	2,165,841	2,765,798	14,493,883
2		452,371	619,817	927,826	1,508,260	1,655,817	1,586,026	1,516,089	8,266,206
3			407,134	557,835	742,260	1,206,608	1,324,654	1,268,821	5,507,313
4				346,064	446,268	467,624	965,286	1,059,723	3,284,966
5					276,851	357,015	444,243	868,758	1,946,866
6						221,481	285,612	377,606	884,699
7							188,259	242,770	431,029
8								160,020	160,020
9									-
10									-
11									-
12									-
13									-
14									-
15									-
16									-
17									-
18									-
	565,464	1,337,824	2,352,416	3,986,382	5,339,093	6,174,297	6,959,921	8,259,585	

Durational Loss Ratio Slope

Ann Dur	2008	2009	2010	2011	2012	2013	2014	2015	mid year durational slope
1	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	
2	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.444
3	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.583
4	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.696
5	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.782
6	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.840
7	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.871
8	0.89	0.89	0.89	0.89	0.89	0.89	0.89	0.89	0.886
9	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.895
10	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.904
11	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.913
12	0.93	0.93	0.93	0.93	0.93	0.93	0.93	0.93	0.922
13	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.931
14	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.940
15	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.950
16	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.959
17	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.969
18	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.979

Expected Claims By Duration and Calendar Year

Ann Dur	2008	2009	2010	2011	2012	2013	2014	2015	Total
1	209,222	327,618	490,422	797,223	875,218	838,328	801,361	1,023,345	5,362,737
2		234,328	321,065	480,614	781,279	857,713	821,562	785,334	4,281,895
3			263,619	361,198	480,614	781,279	857,713	821,562	3,565,985
4				257,688	332,303	348,205	718,776	789,096	2,446,068
5					226,765	292,426	363,874	711,589	1,594,654
6						190,483	245,638	324,757	760,878
7							165,958	214,012	379,970
8								142,475	142,475
9									-
10									-
11									-
12									-
13									-
14									-
15									-
16									-
17									-
18									-
	209,222	561,946	1,075,107	1,896,723	2,696,178	3,308,434	3,974,882	4,812,170	
Exp LR's	**37.0%**	**42.0%**	**45.7%**	**47.6%**	**50.5%**	**53.6%**	**57.1%**	**58.3%**	

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Approval to Publish Amendments to
Rule 69O-191.074,.076,.078
Assignment # 220769-18

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request to approve for publication the proposed rules.

These rules are being amended to update and delete out of date references to government agencies and programs, as well as to incorporate a form for filing a pro forma projection of an anticipated program.

Sections 641.36, 641.22(9), 641.23(3), 641.27, 641.31(5), FS, are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr., is the attorney handling these rules. 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-191.074 Records Retention.

(1) No change.

(2) These records, either in the form of paper or electronic ~~hard~~ documents, ~~microfiche or computer diskettes,~~ shall be maintained for no less than three (3) years, unless otherwise required to be maintained for a longer period of time by the Department of Health, ~~Office of Health and Rehabilitative Services,~~ Internal Revenue Service, Centers for Medicare & Medicaid Services (CMS) ~~Health Care Financing Administration (HCFA)~~ or as otherwise specified by the Office.

Rulemaking Authority 641.36 FS. Law Implemented 641.27 FS. History–New 5-28-92, Formerly 4-191.074, Amended _____.

69O-191.076 Corrective Action Plans.

(1) through (3) No change.

(4) The Office shall approve a corrective action plan complying with section 641.23(3), F.S., if the plan meets all of the following criteria in that the plan includes:

(a) through (d) No change.

(e) A pro forma projecting the anticipated program. Pro forma projections must be submitted electronically on Form OIR-A2-2212, Pro Forma Projections, effective 09/18, hereby incorporated by reference and available at www.flrules.org/XXXXX, via the Office's Regulatory Electronic Filing System (REFS) at https://www.floir.com/iportal.

Rulemaking Authority 641.36 FS. Law Implemented 641.23(3) FS. History–New 5-28-92, Amended 8-15-94, Formerly 4-191.076, Amended _____.

69O-191.078 Subscriber Grievance Procedure.

Every HMO shall have a subscriber grievance procedure. A detailed description of the HMO's subscriber grievance procedure shall be included in all group and individual contracts as well as in any certificate or member handbook provided to subscribers. This procedure shall be administered at no cost to the subscriber. An HMO subscriber grievance procedure must include the following:

(1) through (5) No change.

(6) The HMO shall process the formal written subscriber grievance in a reasonable length of time not to exceed 60 days, unless the subscriber and HMO mutually agree to extend the time frame set forth by this rule. ~~However, any mutually agreed time frame modification will not preclude the subscriber from appealing to the Statewide Subscriber Assistance Panel within the periods as established by this rule.~~ If the complaint involves the collection of information outside the service area, the HMO will have 30 additional days to process the subscriber complaint through all phases of the grievance procedure. The time limitations prescribed in this paragraph requiring completion of the grievance process within 60 days shall be tolled after the HMO has notified the subscriber, in writing, that additional information is required in order to properly complete review of the complaint. Upon receipt by the HMO of the additional information requested, the time for completion of the grievance process set forth herein shall resume. A grievance which is arbitrated pursuant to chapter 682, F.S., is permitted an additional time limitation not to exceed 210 days from the date the HMO receives a written request for arbitration from the subscriber. ~~Arbitration provisions, if any, shall not preclude the subscriber from filing with the Statewide Subscriber Assistance Panel. At the point of the arbitration process the subscriber shall be deemed to have complied with the full formal grievance procedure for the purpose of appealing to the Statewide Subscriber Assistance Panel.~~ Each HMO shall notify the Office of all arbitrated grievances on the quarterly grievance report required by subsection 69O-191.078 (11) ~~(12)~~ , F.A.C.;

~~(7) The subscriber grievance procedure shall state that the subscriber always has the right to appeal to the Office or the Department of Health and Rehabilitative Services. The HMO shall provide to the subscriber written notice of the right to appeal upon completion of the full grievance procedure and supply the Office with a copy of the final decision letter;~~

(7)~~(8)~~ The HMO shall have physician involvement in reviewing medically related grievances. Physician involvement in the grievance process should not be limited to the subscriber's primary care physician, but may include at least one other physician;

(8)~~(9)~~ The HMO shall offer to meet with the subscriber during the formal grievance process. The location of the meeting shall be at the administrative offices of the HMO within the service area or at a location within the service area which is convenient to the subscriber;

(9)~~(10)~~ The HMO may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance;

(10)~~(11)~~ Each HMO shall maintain an accurate record of each formal grievance. Each record shall include the following:

(a) through (d) No change;

(11)~~(12)~~ Each HMO shall submit a quarterly report to the Office pursuant to section 641.311(1)(b), F.S., listing the number and nature of all formal subscriber grievances which have not been resolved to the satisfaction of the subscriber, after the subscriber has utilized the full grievance procedure of the HMO. This report shall be formatted as outlined in the quarterly report of subscriber grievances form incorporated herein by reference and shall be filed with the Office no later than 45 days after the end of each calendar quarter. Quarterly report of subscriber grievance forms can be obtained from the Office of Insurance Regulation's website: http://www.floir.com/iportal.

Rulemaking Authority 641.36 FS. Law Implemented 641.22(9), 641.31(5) FS. History–New 7-8-87, Amended 2-22-88, 10-25-89, Formerly 4-31.078, Amended 5-28-92, Formerly 4-191.078, Amended _____.

INSTRUCTIONS

Tab 'Assumptions':

Type in company name in cell D1
Choose company type from the drop down menu (HMO, PLHSO, DMPO, Health Insurance Company) in cell D2
Please show all assumptions/development that are pertinent to the pro-formas. Utilize formulas as much as possible and minimize use of hard coding.
Key assumptions will need to be sensitivity tested.

Tab 'Balance Sheet':

Input data into the applicable following cells:
year 1: columns C-N
rows 9-19, 23-34, 38-43
year 2: columns P-AA
rows 9-19, 23-34, 38-43
year 3: columns AC-AN
rows 9-19, 23-34, 38-43

Tab 'P and L':

Input ***monthly*** data into the applicable following cells:
year 1: columns C-N
rows 8-15, 19-22, 26, 28-32, 35-39, 44-46, 57, 60
cell C42
year 2: columns R-AC
rows 8-15, 19-22, 26, 28-32, 35-39, 44-46, 57, 60
year 3: columns AG-AR
rows 8-15, 19-22, 26, 28-32, 35-39, 44-46, 57, 60

Tab 'Cash Flow':

Input ***monthly*** data into the applicable following cells:
C42
year 1: columns C-N
rows 9-11, 14-18, 23, 27-31
year 2: columns R-AC
rows 9-11, 14-18, 23, 27-31
year 3: columns AG-AR
rows 9-11, 14-18, 23, 27-31

Tab 'LOB Analysis':

Input ***annual*** data into the applicable following cells:
columns: F-K
year 1: rows 8-13, 17-20, 24, 26-31
year 2: rows 44-49, 53-56, 60, 62-67
year 3: rows 80-85, 89-92, 96, 98-103

Tab 'MLR':

Input ***annual*** data into the applicable following cells:
columns: F-M
year 1: rows 8-12, 16-21, 25, 28-32
year 2: rows 43-47, 51-56, 60, 63-67
year 3: rows 78-82, 86-91, 95, 98-102

Tab 'Stress Test Summary':

Perform Relevant Sensitivity Tests - the ones listed in Column A are suggestions
Step 1: Copy the formulas from row 1 in columns C-V based on the company's initial assumptions and "Paste Special -Values" into the "Base" line
Step 2: Revise the company's input data in each tab based on the specified sensitivity test

Company Name:	Company ABC	
Type: HMO, PLHSO, DMPO	HMO	
Select One:	PLHSO	
	DMPO	
	Health Ins Co	**<==== USER INPUTS**

Show all relevant assumptions used to create the pro-formas.
Beneficial to show formulas and to link to financial statements.
Also, please set up so that relevant assumptions can be sensitivity tested

Assumptions

Company ABC
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

	Year 1 (Monthly)												
	M1Y1	M2Y1	M3Y1	M4Y1	M5Y1	M6Y1	M7Y1	M8Y1	M9Y1	M10Y1	M11Y1	M12Y1	Total Year 1
0. Members	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0
2a. Net Premium Income (Exluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0	0	0	0	0	0	0	0
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Fee for Service	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Risk Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Change in Unearned Premium Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Aggregate Write-Ins for Other Health Related Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Total (L2a,b+L3+L4+L5+L6)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:													
8. Hospital/Medical Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Other Benefits & Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Aggregate Write-Ins for Other Hospital/Medical	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Subtotal (L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less:													
13. Reinsurance Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Total Hospital and Medical (L12 -L13)	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	0	0	0	0	0	0	0	0	0	0	0	0	0
16b. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Increase in Reserves for Accident and Health Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
18. Aggregate Write-Ins for Other Income or Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Net Underwriting Gain or Loss (L7 -L19)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
21. Net Investment Income Earned	0	0	0	0	0	0	0	0	0	0	0	0	0
22. Federal Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Health Insurance Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Net Realized Capital Gains (Losses)	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Less Capital Gains Tax	0	0	0	0	0	0	0	0	0	0	0	0	0
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27. Prior Period Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
28. Net Income	0	0	0	0	0	0	0	0	0	0	0	0	0
29. Capital Increases	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other Increases (Decreases)	0	0	0	0	0	0	0	0	0	0	0	0	0
31. Dividends to Stockholders	0	0	0	0	0	0	0	0	0	0	0	0	0
32. End of Period Surplus (L27+L28+L29+L30-L31)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Minimum Surplus Requirement: HMO: Max[a,b,c]; PLHSO: Max[a,b]; DMPO: $150,000; Health Ins Co: Max[a,d]	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
a. HMO & Health Ins Co: $1,500,000; PLHSO & DMPO: 150,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
b. 10% of Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
c. 2% of Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
d. 4% Total Liabilities + 6% Health Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Excess (Deficit) Surplus	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**
Risk Based Capital (200% ACL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Risk Based Capital	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
2% of Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0

XX/XX/XXXX XX:XX XX

Company ABC
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

	Year 2 (Monthly)												
	M1Y2	M2Y2	M3Y2	M4Y2	M5Y2	M6Y2	M7Y2	M8Y2	M9Y2	M10Y2	M11Y2	M12Y2	Total Year 2
0. Members	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0
2a. Net Premium Income (Exluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0	0	0	0	0	0	0	0
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Fee for Service	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Risk Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Change in Unearned Premium Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Aggregate Write-Ins for Other Health Related Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Total (L2a,b+L3+L4+L5+L6)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:													
8. Hospital/Medical Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Other Benefits & Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Aggregate Write-Ins for Other Hospital/Medical	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Subtotal (L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less:													
13. Reinsurance Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Total Hospital and Medical (L12 -L13)	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	0	0	0	0	0	0	0	0	0	0	0	0	0
16b. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Increase in Reserves for Accident and Health Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
18. Aggregate Write-Ins for Other Income or Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Net Underwriting Gain or Loss (L7 -L19)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
21. Net Investment Income Earned	0	0	0	0	0	0	0	0	0	0	0	0	0
22. Federal Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Health Insurance Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Net Realized Capital Gains (Losses)	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Less Capital Gains Tax	0	0	0	0	0	0	0	0	0	0	0	0	0
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27. Prior Period Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
28. Net Income	0	0	0	0	0	0	0	0	0	0	0	0	0
29. Capital Increases	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other Increases (Decreases)	0	0	0	0	0	0	0	0	0	0	0	0	0
31. Dividends to Stockholders	0	0	0	0	0	0	0	0	0	0	0	0	0
32. End of Period Surplus (L27+L28+L29+L30-L31)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Minimum Surplus Requirement: HMO: Max[a,b,c]; PLHSO: Max[a,b]; DMPO: $150,000; Health Ins Co: Max[a,d]	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
a. HMO & Health Ins Co: $1,500,000; PLHSO & DMPO: 150,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
b. 10% of Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
c. 2% of Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
d. 4% Total Liabilities + 6% Health Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Excess (Deficit) Surplus	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**
Risk Based Capital (200% ACL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Risk Based Capital	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
2% of Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0

Company ABC
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

	Year 3 (Monthly)												
	M1Y3	M2Y3	M3Y3	M4Y3	M5Y3	M6Y3	M7Y3	M8Y3	M9Y3	M10Y3	M11Y3	M12Y3	Total Year 3
0. Members	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0
2a. Net Premium Income (Exluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0	0	0	0	0	0	0	0
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Fee for Service	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Risk Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Change in Unearned Premium Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Aggregate Write-Ins for Other Health Related Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Total (L2a,b+L3+L4+L5+L6)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:													
8. Hospital/Medical Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Other Benefits & Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Aggregate Write-Ins for Other Hospital/Medical	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Subtotal (L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less:													
13. Reinsurance Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Total Hospital and Medical (L12 -L13)	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	0	0	0	0	0	0	0	0	0	0	0	0	0
16b. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Increase in Reserves for Accident and Health Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
18. Aggregate Write-Ins for Other Income or Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Net Underwriting Gain or Loss (L7 -L19)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
21. Net Investment Income Earned	0	0	0	0	0	0	0	0	0	0	0	0	0
22. Federal Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Health Insurance Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Net Realized Capital Gains (Losses)	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Less Capital Gains Tax	0	0	0	0	0	0	0	0	0	0	0	0	0
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27. Prior Period Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
28. Net Income	0	0	0	0	0	0	0	0	0	0	0	0	0
29. Capital Increases	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other Increases (Decreases)	0	0	0	0	0	0	0	0	0	0	0	0	0
31. Dividends to Stockholders	0	0	0	0	0	0	0	0	0	0	0	0	0
32. End of Period Surplus (L27+L28+L29+L30-L31)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Minimum Surplus Requirement: HMO: Max[a,b,c]; PLHSO: Max[a,b]; DMPO: $150,000; Health Ins Co: Max[a,d]	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
a. HMO & Health Ins Co: $1,500,000; PLHSO & DMPO: 150,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
b. 10% of Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
c. 2% of Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
d. 4% Total Liabilities + 6% Health Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Excess (Deficit) Surplus	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**
Risk Based Capital (200% ACL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Risk Based Capital	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
2% of Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0

Company ABC
Pro-Forma Statutory Cash Flow Statement (Florida Experience)

	Year 1 (Monthly)												
	M1Y1	M2Y1	M3Y1	M4Y1	M5Y1	M6Y1	M7Y1	M8Y1	M9Y1	M10Y1	M11Y1	M12Y1	Total Year 1
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Benefits Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Total Cash From Underwriting (L1-L2-L3)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5. Net Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Investments													
11. Net Cash from Investments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
13. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Borrowed Funds	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Dividends	0	0	0	0	0	0	0	0	0	0	0	0	0
16. Other Cash Provided (Applied)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18. Net Cash, Cash Equivalents and Short -Term Investments (L10+L11+L17)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Cash Flow Statement (Florida Experience)

	Year 2 (Monthly)												
	M1Y2	M2Y2	M3Y2	M4Y2	M5Y2	M6Y2	M7Y2	M8Y2	M9Y2	M10Y2	M11Y2	M12Y2	Total Year 2
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Benefits Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Total Cash From Underwriting (L1-L2-L3)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5. Net Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Investments													
11. Net Cash from Investments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
13. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Borrowed Funds	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Dividends	0	0	0	0	0	0	0	0	0	0	0	0	0
16. Other Cash Provided (Applied)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18. Net Cash, Cash Equivalents and Short -Term Investments (L10+L11+L17)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Cash Flow Statement (Florida Experience)

	Year 3 (Monthly)												
	M1Y3	M2Y3	M3Y3	M4Y3	M5Y3	M6Y3	M7Y3	M8Y3	M9Y3	M10Y3	M11Y3	M12Y3	Total Year 3
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Benefits Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Total Cash From Underwriting (L1-L2-L3)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5. Net Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Investments													
11. Net Cash from Investments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
13. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Borrowed Funds	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Dividends	0	0	0	0	0	0	0	0	0	0	0	0	0
16. Other Cash Provided (Applied)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18. Net Cash, Cash Equivalents and Short -Term Investments (L10+L11+L17)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Balance Sheet (Florida Experience)

	Year 1 (YTD)											
	M1Y1	M2Y1	M3Y1	M4Y1	M5Y1	M6Y1	M7Y1	M8Y1	M9Y1	M10Y1	M11Y1	M12Y1
Admitted Assets												
1. Bonds	0	0	0	0	0	0	0	0	0	0	0	0
2. Stock	0	0	0	0	0	0	0	0	0	0	0	0
3. Real Estate/Mortgage Investments	0	0	0	0	0	0	0	0	0	0	0	0
4. Cash/Cash Equivalents	0	0	0	0	0	0	0	0	0	0	0	0
5. Health Insurers Provider Fee (from AHCA)	0	0	0	0	0	0	0	0	0	0	0	0
6. Affiliated Receivables	0	0	0	0	0	0	0	0	0	0	0	0
7. Affiliated Investments	0	0	0	0	0	0	0	0	0	0	0	0
8. Aggregate Write-Ins for Invested Assets	0	0	0	0	0	0	0	0	0	0	0	0
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable	0	0	0	0	0	0	0	0	0	0	0	0
10. Amounts Recoverable from Reinsurers	0	0	0	0	0	0	0	0	0	0	0	0
11. Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	0	0	0	0	0	0	0	0	0	0	0	0
14. Unpaid Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	0	0	0	0	0	0	0	0	0	0	0	0
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable	0	0	0	0	0	0	0	0	0	0	0	0
15c. Aggregate Health Policy Reserves - MLR Rebate	0	0	0	0	0	0	0	0	0	0	0	0
16. Aggregate Life Policy Reserves	0	0	0	0	0	0	0	0	0	0	0	0
17. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
18. General Expenses Due or Accrued	0	0	0	0	0	0	0	0	0	0	0	0
19. Ceded Reinsurance Payable	0	0	0	0	0	0	0	0	0	0	0	0
20. Payable to Parents, Subsidiaries & Affiliates	0	0	0	0	0	0	0	0	0	0	0	0
21. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	0	0	0	0	0	0	0	0	0	0	0	0
22. Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
23. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21+L22)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital and Surplus												
24. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	0	0	0	0	0	0	0	0	0	0	0	0
25. Capital Stock	0	0	0	0	0	0	0	0	0	0	0	0
26. Gross Paid In and Contributed Surplus	0	0	0	0	0	0	0	0	0	0	0	0
27. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
28. Unassigned Surplus	0	0	0	0	0	0	0	0	0	0	0	0
29. Other Items(elaborate)	0	0	0	0	0	0	0	0	0	0	0	0
30. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Balance Sheet (Florida Experience)

	Year 2 (YTD)											
	M1Y2	M2Y2	M3Y2	M4Y2	M5Y2	M6Y2	M7Y2	M8Y2	M9Y2	M10Y2	M11Y2	M12Y2
Admitted Assets												
1. Bonds	0	0	0	0	0	0	0	0	0	0	0	0
2. Stock	0	0	0	0	0	0	0	0	0	0	0	0
3. Real Estate/Mortgage Investments	0	0	0	0	0	0	0	0	0	0	0	0
4. Cash/Cash Equivalents	0	0	0	0	0	0	0	0	0	0	0	0
5. Health Insurers Provider Fee (from AHCA)	0	0	0	0	0	0	0	0	0	0	0	0
6. Affiliated Receivables	0	0	0	0	0	0	0	0	0	0	0	0
7. Affiliated Investments	0	0	0	0	0	0	0	0	0	0	0	0
8. Aggregate Write-Ins for Invested Assets	0	0	0	0	0	0	0	0	0	0	0	0
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable	0	0	0	0	0	0	0	0	0	0	0	0
10. Amounts Recoverable from Reinsurers	0	0	0	0	0	0	0	0	0	0	0	0
11. Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	0	0	0	0	0	0	0	0	0	0	0	0
14. Unpaid Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	0	0	0	0	0	0	0	0	0	0	0	0
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable	0	0	0	0	0	0	0	0	0	0	0	0
15c. Aggregate Health Policy Reserves - MLR Rebate	0	0	0	0	0	0	0	0	0	0	0	0
16. Aggregate Life Policy Reserves												
17. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
18. General Expenses Due or Accrued	0	0	0	0	0	0	0	0	0	0	0	0
19. Ceded Reinsurance Payable	0	0	0	0	0	0	0	0	0	0	0	0
20. Payable to Parents, Subsidiaries & Affiliates	0	0	0	0	0	0	0	0	0	0	0	0
21. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	0	0	0	0	0	0	0	0	0	0	0	0
22. Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
23. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21+L22)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital and Surplus												
24. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	0	0	0	0	0	0	0	0	0	0	0	0
25. Capital Stock	0	0	0	0	0	0	0	0	0	0	0	0
26. Gross Paid In and Contributed Surplus	0	0	0	0	0	0	0	0	0	0	0	0
27. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
28. Unassigned Surplus	0	0	0	0	0	0	0	0	0	0	0	0
29. Other Items(elaborate)	0	0	0	0	0	0	0	0	0	0	0	0
30. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Balance Sheet (Florida Experience)

	Year 3 (YTD)											
	M1Y3	M2Y3	M3Y3	M4Y3	M5Y3	M6Y3	M7Y3	M8Y3	M9Y3	M10Y3	M11Y3	M12Y3
Admitted Assets												
1. Bonds	0	0	0	0	0	0	0	0	0	0	0	0
2. Stock	0	0	0	0	0	0	0	0	0	0	0	0
3. Real Estate/Mortgage Investments	0	0	0	0	0	0	0	0	0	0	0	0
4. Cash/Cash Equivalents	0	0	0	0	0	0	0	0	0	0	0	0
5. Health Insurers Provider Fee (from AHCA)	0	0	0	0	0	0	0	0	0	0	0	0
6. Affiliated Receivables	0	0	0	0	0	0	0	0	0	0	0	0
7. Affiliated Investments	0	0	0	0	0	0	0	0	0	0	0	0
8. Aggregate Write-Ins for Invested Assets	0	0	0	0	0	0	0	0	0	0	0	0
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable	0	0	0	0	0	0	0	0	0	0	0	0
10. Amounts Recoverable from Reinsurers	0	0	0	0	0	0	0	0	0	0	0	0
11. Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	0	0	0	0	0	0	0	0	0	0	0	0
14. Unpaid Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	0	0	0	0	0	0	0	0	0	0	0	0
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable	0	0	0	0	0	0	0	0	0	0	0	0
15c. Aggregate Health Policy Reserves - MLR Rebate	0	0	0	0	0	0	0	0	0	0	0	0
16. Aggregate Life Policy Reserves												
17. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
18. General Expenses Due or Accrued	0	0	0	0	0	0	0	0	0	0	0	0
19. Ceded Reinsurance Payable	0	0	0	0	0	0	0	0	0	0	0	0
20. Payable to Parents, Subsidiaries & Affiliates	0	0	0	0	0	0	0	0	0	0	0	0
21. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	0	0	0	0	0	0	0	0	0	0	0	0
22. Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
23. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21+L22)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital and Surplus												
24. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	0	0	0	0	0	0	0	0	0	0	0	0
25. Capital Stock	0	0	0	0	0	0	0	0	0	0	0	0
26. Gross Paid In and Contributed Surplus	0	0	0	0	0	0	0	0	0	0	0	0
27. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
28. Unassigned Surplus	0	0	0	0	0	0	0	0	0	0	0	0
29. Other Items(elaborate)	0	0	0	0	0	0	0	0	0	0	0	0
30. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Analysis of Operations by Line Of Business (Florida Experience)

End of Year 1	Total	Comprehensive	Dental	Vision	Medicare	Medicaid
1a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0
1b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0
2. Fee for Service	0	0	0	0	0	0
3. Risk Revenue	0	0	0	0	0	0
4. Change in unearned premium reserves	0	0	0	0	0	0
5. Aggregate write in for other health related revenue	0	0	0	0	0	0
6. Total (L1a,b+L2+L3+L4+L5)	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:						
7. Hospital/Medical Benefits	0	0	0	0	0	0
8. Other professional Services	0	0	0	0	0	0
9. Prescription Drugs	0	0	0	0	0	0
10. Aggregate write ins for other hospital/medical	0	0	0	0	0	0
11. Subtotal (L7+L8+L9+L10)	**0**	**0**	**0**	**0**	**0**	**0**
Less:						
12. Reinsurance recoveries	0	0	0	0	0	0
13. Total hospital and Medical (L11 -L12)	0	0	0	0	0	0
14. Claims adjustment expenses	0	0	0	0	0	0
15a. General admin expenses (excluding HIP Fee & User Fee paid)	0	0	0	0	0	0
15b. Health Insurance Fee Paid	0	0	0	0	0	0
15c. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0
16. Increase in reserves for accident and health contacts	0	0	0	0	0	0
17. Aggregate write in for other income or expenses	0	0	0	0	0	0
18. Total underwriting deductions (L13+L14+L15a,b,c+L16+L17)	**0**	**0**	**0**	**0**	**0**	**0**
19. Net underwriting gain or loss (L6 -L18)	**0**	**0**	**0**	**0**	**0**	**0**
Administrative Ratio (L15a/L6)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Other
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Company ABC
Preliminary MLR (Florida Experience)

End of Year 1	Total	Individual Comprehensive	Small Group Comprehensive	Large Group Comprehensive	Medicare (MA/Pt D)	Individual Mini-Meds	Small Group Mini-Meds	Large Group Mini-Meds	Expatriate Plans
1. Premiums Earned	0	0	0	0	0	0	0	0	0
2. Federal Taxes/Federal Assessments	0	0	0	0	0	0	0	0	0
3. State Insurance, Premium, and Other Taxes	0	0	0	0	0	0	0	0	0
4a. Regulatory Authority License and Fees	0	0	0	0	0	0	0	0	0
4b. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0
5. Adjusted Premium Earned (L1-L2-L3-L4a,b)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6. Incurred Claims Excluding Prescription Drugs	0	0	0	0	0	0	0	0	0
7. Prescription Drugs	0	0	0	0	0	0	0	0	0
8. Pharmaceutical Rebates	0	0	0	0	0	0	0	0	0
9. State Stop Loss, Market Stabilization and Claim/Census Based Assessments	0	0	0	0	0	0	0	0	0
10. Net Risk Adjustment (+Payments - Recoverables)	0	0	0	0	0	0	0	0	0
11. Incurred Medical Incentive Pools and Bonuses	0	0	0	0	0	0	0	0	0
12. Total Incurred Claims (L6+L7-L8-L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
13. Deductible Abuse Detection/Recovery Expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
14. Improved Health Outcomes	0	0	0	0	0	0	0	0	0
15. Activities to Prevent Hospital Readmissions	0	0	0	0	0	0	0	0	0
16. Improve Patient Safety and Reduce Medical Errors	0	0	0	0	0	0	0	0	0
17. Wellness and Health Promotion Activities	0	0	0	0	0	0	0	0	0
18. QI Health Information Technology Expenses	0	0	0	0	0	0	0	0	0
19. Total Expenses Incurred for Improving Health Quality (L14+L15+L16+L17+L18)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
20. Preliminary MLR ((L12+L13+L19)/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Company ABC
Summary of Results

	End of Year 1						End of Year 2						End of Year 3					
Scenario Description	Members	Net Cash	Net Income	Surplus	Required Surplus	Excess (Deficit)	Members	Net Cash	Net Income	Surplus	Required Surplus	Excess (Deficit)	Members	Net Cash	Net Income	Surplus	Required Surplus	Excess (Deficit)
Base																		
Increase Admin Expenses x%																		
Decrease Admin Expenses x%																		
Increase New Sales x%																		
Decrease New Sales x%																		
Increase Loss Ratio x%																		
Decrease Loss Ratio x%																		

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Final Approval to Adopt Repeal of Rules 69O-203.204,.205
Assignment # 231664-18

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request for Final Approval to Adopt the proposed rules.

The notice of proposed rules was published on December 10, 2018, in Volume 44, No. 238, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

The rules govern the Office's review of discount medical plan products. The statutory authority for these rules has been repealed; therefore, the rules are being repealed.

Sections 636.232, 624.424(1)(c); 636.208; 636.216; 636.230, F.S., are the rulemaking authority and laws implemented for these rules.

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

Michael Lawrence, Jr., 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

69O-203.204 Filing, Approval of DPO ~~DMPO~~ Plans, Rates and Related Forms.

Rulemaking Authority 636.232 FS. Law Implemented 624.424(1)(c), 636.208, 636.216 FS. History–New 4-7-05, Amended 5-4-06, 11-1-07, Repealed _____.

69O-203.205 Bundled Products.

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.230 FS. History–New 5-4-06, Amended 11-1-07, Repealed _____.

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Final Approval to Adopt Amendments to
Rule 69O-203.201,.202,.203,.210
Assignment # 231661-18

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request for Final Approval to Adopt the proposed rules.

The notice of proposed rules was published on December 10, 2018, in Volume 44, No. 238, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

These rules will be updated to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida, renaming "discount medical plan organizations" to "discount plan organizations" and revising conditions for reimbursement, disclosure requirements, reporting requirements, fee requirements, marketing requirements, and the authority for the Financial Services Commission to adopt rules.

Sections 624.424, 636.232, 636.202, 636.204, 636.216, 636.218, 636.220, 636.226, 636.234, 636.236, F.S., are the rulemaking authority and laws implemented for these rules.

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

Michael Lawrence, Jr., is the attorney handling these rules. 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

69O-203.201 Definitions.

(1) No change.

(2) Contract or Form means the document, by whatever name called; such as agreement, certificate or handbook which describes the benefits under the Ddiscount ~~medical~~ Plan.

(3) Discount ~~Medical~~ Plan (Plan) means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for Pplan members to providers of medical services and the right to receive one or more medical services from those providers at a discount.

(4) DPO ~~DMPO~~ is the Discount ~~Medical~~ Plan Organization defined in Section 636.202(2), F.S., that contracts with providers, provider networks, or other DPOs, ~~DMPOs,~~ to provide discounted medical services to Plan members and determines the charges to the members.

(5) No change.

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.202 FS. History–New 4-7-05, Amended _____.

69O-203.202 Standards for Discount ~~Medical~~ Plans.

(1) No change.

(a) Name and address of the DPO ~~DMPO~~;

(b) through (l) No change.

(j) Provisions for adding new family members; and

~~(k) All plan contracts and application forms shall have a unique form number in the lower left hand corner; and~~

(k)~~(l)~~ Member complaint procedure.

(2) No change.

~~(3) (a) All charges to members must be filed with the Office, and the Office must approve any periodic charge exceeding $30.00 per month, or $50.00 per month as provided by paragraph 69O-203.204(1)(b), F.A.C., for the contract issued and not per member covered on the contract, before the periodic charges can be used. Periodic charges approved pursuant to this paragraph must remain in compliance with this paragraph. Consequently, subsequent to the initial approval, the periodic charges remain subject to review by the Office to ensure continued compliance.~~

~~(b) In a filing made pursuant to paragraph (a) above, the discount medical plan organization has the burden of proof that the periodic charges bear a reasonable relationship to the benefits received by the member. If the discount medical plan organization uses member savings as the basis of demonstrating the benefits received by the member, the benefits shall be benefits and savings that can be reasonably anticipated by an average Floridian who may purchase such contract.~~

~~(c) A discount medical plan organization may, at its option, make a filing that meets one of the following standards that have been determined to meet the requirement of paragraph (b) above:~~

~~1. The discount medical plan organization provides financial information to demonstrate that at least sixty percent (60%) of the periodic charge is used to pay the costs associated with providing access to discount medical services, excluding any administrative costs, commissions and profits; or~~

~~2. The discount medical plan organization provides financial information to demonstrate that the plan's periodic charge does not exceed sixty percent (60%) of the actual benefit of the discounted services to members, measured as the actual savings realized by members, i.e., provider billed charges without the discount less the discounted provider charges paid by the member. These values shall be measured in the aggregate for all members and all actual services utilized over a period of twelve months with experience from at least 2,000 members; or~~

~~3. The discount medical plan organization provides specific financial information to demonstrate that at least seventy five percent (75%) of the periodic charge is used to pay the costs associated with providing access to discount medical services, member support services and administrative costs excluding commissions and profits.~~

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.216 FS. History–New 4-7-05, Amended 11-1-07, _____.

69O-203.203 Standards for the Form and Content of Advertisements or Marketing Materials.

(1) No change.

(2) (a) through (c) No change.

(d) The term "insurance" may not be used as a descriptive term for DPO ~~DMPO~~ benefits. However, the term "insurance" may be used in a disclaimer of any relationship between DPO ~~DMPO~~ benefits and insurance including the disclosures required in Section 636.212, F.S.

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.228 FS. History–New 4-7-05, Amended _____.

Substantial rewording of Rule 69O-203.210, F.A.C. follows. See Florida Administrative Code for present text.

69O-203.210 Forms Incorporated by Reference.

(1) The following forms are hereby incorporated by reference:

(a) Form OIR-C1-1606, Application for License Discount Plan Organization (DPO), effective 01/18, available at www.flrules.org/XXXXX;

(b) Form OIR-C1-1423, Biographical Affidavit, effective 03/18, available at www.flrules.org/XXXXX;

(c) Form OIR-C1-938, Fingerprint Payment and Submission Procedure, effective 10/18, available at www.flrules.org/XXXXX;

(d) Form OIR-C1-144, Service of Process Consent & Agreement, effective 06/04, available at www.flrules.org/XXXXX;

(e) Form OIR-C1-1298, Management Information Form Complete List of Officers, Directors, and Shareholders (10% or more), effective 03/18, available at www.flrules.org/XXXXX; and

(f) OIR-A1-1671, Annual Report – Discount Plan Organizations (05/18), available at www.flrules.org/XXXXX;

(g) Form OIR-C1-905, Instructions for Funishing Background Investigative Reports, effective 02/15, available at www.flrules.org/XXXXX.

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

Rulemaking Authority 624.424(1)(c), 636.232 FS. Law Implemented 624.424, 636.204, 636.218, 636.220, 636.226, 636.228, 636.234, 636.236 FS. History–New 5-22-05, Amended 10-29-08, 7-30-17, Amended _____.

Office of Insurance Regulation
Company Admissions

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

The Office receives applications electronically. Please submit your application at http://www.floir.com/iportal, using the iApply link to Online Company Admissions.

This package is designed to assist individuals in preparing the application with all the information required by statute and to facilitate expeditious processing of the application by this Office.

PLEASE NOTE: THE COMPLETED CHECK LIST MUST BE SUBMITTED WITH THE APPLICATION PACKAGE.

The completed application package must be submitted to the Office by utilizing the following link:

http://www.floir.com/iportal
and select iApply – Online Company Admissions

If this package requires submission of forms and/or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal http://www.floir.com/iportal and select "Form & Rate Filing Assembly and Submission" to begin the submission of forms and/or rates.

If this package requires original documents, in lieu of providing original paper documents, the Applicant is directed to submit a PDF of the original document(s) unless otherwise required by Florida Statutes.

Any questions concerning this application package may be directed to the Application Coordinatorat appcoord@floir.com. For iApply only questions, contact the Application Coordinator at iapply@floir.com

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

Pursuant to Section 636.Part II, Florida Statutes, in order to do business as a Discount Plan Organization (DPO), an entity must:

A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, Part I of Chapter 607, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S.
[s., 636.204(1), F.S.];

B. Be an entity, which in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fee

The application filing fee is $50.00. The initial fee is due and payable at the time of filing the application for licensure. [s.636.204(2)(l) and s.636.204(5), F.S.]

Secure the check to the invoice, which is included in this package, and send to:

Florida Department of Financial Services
Revenue Processing Section
P.O. Box 6100
Tallahassee, Florida 32314-6100

Submit a copy of the invoice and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Processing Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938 for instructions.

Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see form OIR-C1-938 for instructions.

Section I-3 Application for License (Official Form included with this package)

This form must be sworn to by an officer or authorized representative of the applicant.

SECTION II-LEGAL

Section II-1 Articles of Incorporation

Include in this section the applicant's Articles of Incorporation or other organizing documents, including all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original. [s.636.204(2)(a), F.S.]

Section II-2 Certificate of Status from Florida Secretary of State

Provide a Certificate of Status document issued by the Florida Secretary of State which certifies that the applicant is authorized in this State and that all state taxes and fees

have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s.636.204(1), F.S.]

If you have any questions concerning filing with the Secretary of State, please contact the Division of Corporations at (850) 245-6051 or see http://www.sunbiz.org/.

Important note: The Secretary of State will issue a charter to a discount plan organization before the Office completes its processing of an application for a license. This charter authorizes the company to engage in any type of business except insurance or discount plans, or other regulated business.

Your company MAY NOT engage in the business of a discount plan in Florida until it has been issued a license by the Commissioner of the Office.

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include a copy of the applicant's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be signed, and recently dated by the Secretary of the company. No signature other than the Secretary's will be accepted. [s. 636.204(2)(b), F.S.]

Section II-4 Certificate of Compliance (Foreign Applicants Only)

If applicable, provide a Certificate of Compliance issued by the public official having supervision in applicant's state of domicile showing that the company is organized and authorized to issue contracts and the kinds of contracts it is authorized to transact. The certificate should be an original under seal by the organization's state of domicile. If not applicable, please state this in the application.

Section II-5 Service of Process Form

[s.636.234, 624.422 and 624.423 F.S.]

Provide an executed Service of Process Consent and Agreement form (official form included in this package) under corporate seal and signed by the president or chief executive officer and secretary.

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of discounts to be offered, and advertising media to be used.
[s. 636.204(2)(j), F.S.]

Section III-2 Advertising

Provide a description of the procedures in place for the DPO to approve advertising, prior to use, pursuant to Section 636.228, Florida Statutes.

Section III-3 Website

Prior to licensure by the Office, each DPO must establish an Internet website that conforms to the requirements of Section 636.226, Florida Statutes. [s. 636.204(4)] This website should also comply with the disclosures required in s. 636.212, F.S. and should not include any prohibitions listed in s. 636.210, F.S.

Provide the address of the website that complies with these statutes.

Section III-4 Financial

A. Submit a copy of the applicant's most recent financial statements audited by an independent certified public accountant [s.636.204,(2)(i), F.S.], and provide the date of the company's fiscal year end.

B. Each DPO must at all times maintain a net worth of at least $150,000. [s.636.220(1), F.S.]

The OFFICE may not issue a license unless the DPO has a net worth of at least $150,000.
[s.636.220(2), F.S.]

C. Documentation that the applicant has complied with the surety bond or security deposit requirements [636.236(1), Florida Statutes]. For security deposits, contact the Bureau of Collateral Management at (850) 413-3167.

(1) Each DPO must maintain in force (unless deposit is placed in lieu of the bond) a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the Office to protect the financial interest of members who may be adversely affected by the insolvency of a DPO. The bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of #1 above, each DPO shall deposit with the Bureau of Collateral Management cash or securities of the type eligible under Section 625.52, Florida Statues, which shall have at all times a market value of $35,000.

(3) If for any reason the market value of assets and securities of DPO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.

Section III-5 **Contractual**

A. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members. [s. 636.204(2)(f), F.S.]

B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members. [s. 636.204(2)(h), F. S.]

C. A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in the Management Section (Section IV) of this application as individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10% or more voting securities of the applicant. [s. 636.204(2)(c) and (g), F.S.]

Section III-6 A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered. [s. 636.204(2)(e), F.S.]

Section III-7 A description of the subscriber complaint procedures to be established and maintained. [s. 636.204,(2)(k), F.S.]

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

SECTION IV - MANAGEMENT

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

Section IV-1 List of All Officers, Directors, and Shareholders [s.636.204(2)(c) F.S.]

A. List the names, addresses and official positions of each officer, director and any person having direct or indirect control of the organization, including but not limited to contracted management company personnel (form included in this package).

B. List the names of each shareholder owning ten percent or more of voting securities of the applicant or any person having the right to acquire ten percent or more of the voting securities of the applicant (issued and outstanding warrants/options, etc.). Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the DPO, including any possible conflicts of interest.

C. If the applicant is a subsidiary of a parent or holding company, provide an organizational chart showing the relationship of all related companies.

Section IV-2 Biographical Affidavits for Officers, Directors and Shareholders [s.636.204(2)(d),F.S.]

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, any person having direct or indirect control of the organization, including but not limited to contracted management company personnel and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. All "Yes" answers must be explained.

Each biographical affidavit must contain an original signature and original notary seal.

The requirement for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to Sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on the Biographical Affidavit, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also please mark CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and

responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 Investigative Background Reports [636.204(2)(d) F.S.]

A Background Investigative Report must be provided for each person listed in Section IV-1 above except for those companies in the organizational structure between the immediate parent and the ultimate parent. Background reports must be submitted by the selected background investigator vendor prior to or contemporaneously with the application filing. Please refer to form OIR-C1-905 REV 02/15 for instructions.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in Section IV-1. The cards will be furnished by the Office upon request. **No cards other than those furnished by the Office will be accepted.** The cards must be completed at a law enforcement agency and returned to this Office for processing. Please refer to Form OIR-C1-938 for instructions.

Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards and fees as noted above. Please refer to Form OIR-C1-938.

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #		Completion Check List
1.	Insurer application fees paid.....	☐
	(a) Copy of invoice included (Official Form).....	☐
	(b) Copy of check.....	☐
	(c) Originals mailed to Revenue Processing Section.....	☐
2.	Fingerprint fee paid electronically.....	☐
	a. Copy of on-line payment confirmation.....	☐
3.	Application for License (Official Form).....	☐
	(a) All blanks completed.....	☐
	(b) If applicable, sealed by corporation.....	☐
	(c) Signed by President or other authorized officer (original signature).....	☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

SECTION II – LEGAL

Company Name: _____

Item #		Completion Check List
1.	Articles of Incorporation or other organizing documents and all amendments attached with an original certification by the State of Domicile	☐
2.	Certificate of Status from Florida Secretary of State (original document)	☐
	(a) Good standing indicated.....	☐
	(b) Sealed by state.....	☐
	(c) Signed by proper public official.....	☐
	(d) Original.....	☐
3.	Corporate By-Laws, Rules and Regulations, and/or Constitution	☐
	(a) Signed and dated by applicant's secretary.....	☐
4.	Certificate of Compliance from State of domicile.....	☐
	(a) Original Certification from State of domicile.....	☐
	(b) Form indicates the kinds of contracts the company is authorized to transact.....	☐
	(c) Not applicable.....	☐
5.	Service of Process Form.....	☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

Item #		Completion Check List
1.	Marketing and growth	☐
	(a) Description of marketing methods.....	☐
2.	Advertising.....	☐
	(a) Include a description of advertising procedures.....	☐
3.	Provide website address.....	☐
4.	Financial	☐
	A. Current audited financial statements & fiscal year end date...	☐
	B. Compliance with minimum surplus requirement.....	☐
	C. Original document evidencing compliance with surety bond requirement or security deposit requirement as explained in S.III-4C 1&2.....	☐
5.	Contractual Documents	☐
	(a) Provider contract form	☐
	(b) Other forms of contracts per s.636.204(2)(h), F.S.	☐
	(c) Other forms of contracts per s.636.204(2)(c) and (g), F.S.....	☐
6.	Statement describing facilities, personnel, and medical services...	☐
7.	Description of subscriber complaint procedures.....	☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

SECTION IV – MANAGEMENT

Note: This portion of the checklist is detailed in order to assist the applicant in ensuring all items are completed, and checklist item numbers will not correlate with item numbers in the Instructions.

Item #		Completion Check List
1.	Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-1298)	☐
2.	Listing of all immediate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
3.	Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298). Note, do not complete Form OIR-C1-1423, (Biographical Affidavits) or order investigative reports or fingerprint cards.....	☐
4.	Listing of all ultimate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
5.	Organizational Chart including all entities within the ultimate parent company structure.....	☐
6.	Biographical Affidavits for company officers, directors, and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423)	☐
	As to each biographical:	
	(a) All blanks completed.....	☐
	(b) Contains original signature.....	☐
	(c) Notarized (original)	☐
	(d) SSN on a separate page.....	☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

SECTION IV – MANAGEMENT
Required Filing and Check list

7. Biographical Affidavits for immediate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent Company's stock (Form OIR-C1-1423) ..... ☐

As to each biographical:

(a) All blanks completed..... ☐

(b) Contains original signature..... ☐

(c) Notarized (original)..... ☐

(d) SSN on a separate page..... ☐

8. Biographical Affidavits for ultimate parent(s) officers, directors, and Shareholders (including entities) owning 10% or more of parent company's Stock (Form OIR-C1-1423)

As to each biographical:

(a) All blanks completed..... ☐

(b) Contains original signature..... ☐

(c) Notarized (original)..... ☐

(d) SSN on a separate page..... ☐

9. Background investigative reports for company officers, directors, and shareholders (including entities) owning 10% or more of applicant..... ☐

10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock..... ☐

11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock..... ☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

Note: If fingerprints are digitally scanned, Items 12, 13 and 14 are not applicable.

12. Fingerprint cards completed for each company officer, director, and shareholder (including entities) owning 10% or more of applicant ..... ☐

As to each fingerprint card:

(a) Contains original signature..... ☐

(b) Florida cards only..... ☐

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ..... ☐

13. Fingerprint cards completed for each immediate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

As to each fingerprint card:

(a) Contains original signature..... ☐

(b) Florida cards only..... ☐

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ..... ☐

14. Fingerprint cards completed for each ultimate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

(a) Contains original signature..... ☐

(b) Florida cards only..... ☐

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page)..... ☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by (Entity Name)_____ that he/she has read said application, that he/she knows the contents thereof and verifies that the items indicated in the application checklist have been submitted with the application, that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the applicant on behalf which the person acted, executed the instrument**.**

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

Dated _____ _____
(Give full and exact name of applicant)

_____
Signature of President, Secretary, or Treasurer

_____ _____
Printed Name Printed Title

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

Pursuant to Chapter 636, Part II Florida Statutes, application is hereby submitted to form and operate a Discount Plan Organization.

In order to qualify as a Discount Plan Organization (DPO), an entity must:

A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, part I of Chapter 607, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S. [s., 636.204(1), F.S.];

B. Be an entity which, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

Proposed name of Discount Plan Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE:_____

CONTACT PERSON: _____

E-MAIL:_____ FAX:_____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE:_____ E-MAIL:_____ FAX:_____

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

This company, through its duly authorized officers, hereby applies for a license authorizing and empowering it to operate as a discount plan 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

Form OIR-C1-1606
Rev 01/18
Rule 69O-203.210

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

INVOICE
PAYMENT OF APPLICATION FEE

NAME OF COMPANY: _____

FEIN #: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

_____

_____
(CITY) (STATE) (ZIP CODE)

E-MAIL ADDRESS: _____ FAX: _____

In reference to the recent submission by the above-referenced discount ~~medical~~ plan organization regarding its application to do business in Florida, it is necessary that you return this form with the proper payment as listed below.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail check and invoice only to the Florida Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100.

2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

If you have any questions, please contact Applications Coordination at (850) 413-2575.

	B/T	TY/CL	F/T	AMOUNT
Filing Fee	C	1249F	F	$ 50.00

Form OIR-C1-1606
Rev 01/18
Rule 69O-203.210

BIOGRAPHICAL AFFIDAVIT

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

(Print or Type)

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

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

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 and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name : ______________________________ NAIC No. ____________________________
FEIN: ____________________________

6. List of memberships in professional societies and associations:

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. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending
Dates (MM/YY):_________-___________Employer's Name: ____

Address:______________________________City:__________________________State/Province: _______________________

Country:_______________Postal Code:___________Phone:_____________Offices/Positions Held: _____________________

Type of Business:______________________________ Supervisor/Contact: ____

Beginning/Ending
Dates (MM/YY):_________-___________Employer's Name: ____

Address:______________________________City:__________________________State/Province: _______________________

Country:_______________Postal Code:___________Phone:_____________Offices/Positions Held:_____________________

Type of Business:______________________________ Supervisor/Contact: ____

Beginning/Ending
Dates (MM/YY):_________-___________Employer's Name: ____

Address:______________________________City:__________________________State/Province: _______________________

Country:_______________Postal Code:___________Phone:_____________Offices/Positions Held:_____________________

Type of Business:______________________________ Supervisor/Contact: ____

Beginning/Ending
Dates (MM/YY):_________-___________Employer's Name: ____

Address:______________________________City:__________________________State/Province: _______________________

Country:_______________Postal Code:___________Phone:_____________Offices/Positions Held:_____________________

Type of Business:______________________________ Supervisor/Contact: ____

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, 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 ☐

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

_____

_____

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

Dated and signed this _____ day of _____ 20 at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

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

_____
(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me 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

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

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

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

_____

_____

_____

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____
   IF ANSWER IS "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. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

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

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

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

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

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

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

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.

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

_____
(Signature of Affiant)

State of:_____ County of: _____

The foregoing instrument was acknowledged before me 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

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

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

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

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

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

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

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of:_____ County of: _____

The foregoing instrument was acknowledged before me this _____ day of_____, 20_____by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

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

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(***Minnesota and Oklahoma***)

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

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

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

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

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

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

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me 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

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(*California)*

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

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

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

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

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

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

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

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of:_____County of _____

The foregoing instrument was acknowledged before me 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

Office of Insurance Regulation
Company Admissions

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Individuals subject to the fingerprinting process must be registered through IdentoGO by Idemia, formerly MorphoTrust USA, at https://fl.ibtfingerprint.com/**.** Individuals may contact the Customer Service Center at 1-800-528-1358 regarding payment, processing or appointment issues.

LiveScan (available to Florida Residents):

Access https://fl.ibtfingerprint.com/**,** select "Schedule a New Appointment" and continue. Retain copy of payment confirmation. Payment confirmations will be a required component in the electronic application submitted via iApply.

Paper Card (available to Non-Residents or Florida residents who affirm they are physically unable to be digitally fingerprinted):

Access https://fl.ibtfingerprint.com/**, s**elect "Register for Fingerprint Card Processing Service" and continue. Select "No Cards" on the Shipping Details screen. Retain copy of payment confirmation. Payment confirmations will be a required component in the electronic application submitted via iApply.

Individuals must complete **two** fingerprint cards provided by the Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com.

Fingerprints must be taken by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

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

Mail ONLY completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
200 East Gaines Street, Room B-15
Tallahassee, Florida 32399-0326

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

CONFIDENTIAL

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

Applicant's Name: _____
Applicant's Social Security Number: _____

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

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

CONFIDENTIAL

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 _____

_____ _____ _____
FEI# *FL Company Code* *Telephone#*

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

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

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

Designated Person to receive process: _____ ***E-Mail Address:*** _____
Phone#: _____ ***Fax#*** _____

Mailing Address: _____ ***Street Address*** — — — — — — — — — — — — — — —
_____ _____
_____ _____

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

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

_____
President or CEO's Signature

_____
President or CEO's Name (Typed or Printed)

SEAL

_____
Secretary's Signature

_____
Secretary's Name (Typed or Printed)

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

69O-203.210
69O-203.100
69O-191.107
0IR-Cl-144
Rev 06/2004

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

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION (UCAA)
Management Information Form
Complete Listing of Incorporators*, Officers
Directors and Shareholders (10% or more)

Incorporators*	Titles:	Ownership Percentage:

Officers:

Directors:

Shareholders:

* Primary Application Only

Office of Insurance Regulation
Life & Health Financial Oversight

FLORIDA
COMPANY CODE:
__ __ __ __ __

FEDERAL EMPLOYER
IDENTIFICATION NUMBER
__ __ -- __ __ __ __ __ __ __

ANNUAL REPORT

OF THE

_____

NAME OF THE DISCOUNT PLAN ORGANIZATION (DPO)

_____

(CITY)

_____

(STATE)

TO THE

OFFICE OF INSURANCE REGULATION

OF THE

STATE OF FLORIDA

Life & Health Financial Oversight
200 East Gaines Street
Tallahassee, FL 32399 - 0327

FOR THE FISCAL YEAR ENDED

_____

DUE ON OR BEFORE

3 MONTHS AFTER THE END OF EACH FISCAL YEAR END

REPORT MUST BE TYPED OR PRINTED

Form OIR-A1-1671
(05/18)
69O-203.210

Name of Discount Plan Organization (DPO):

_____

Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending_____

Federal Employer Identification Number (FEIN)	__ __ -- __ __ __ __ __ __ __
Complete address of DPO's principal office	
Full name & title of DPO's chief executive officer	
Web Site (s. 636.204 (4))	
Type of entity (check one)	___ Corporation - For profit ___ Sole proprietorship ___ Corporation - Not-for-profit ___ Limited liability company ___ Partnership ___ Other:

This annual report shall be signed below by two corporate officers of the DPO, if the DPO is a corporation; the DPO's partners, if the DPO is a partnership; the DPO's owner, if the DPO is a sole proprietorship; or the DPO's managing or other duly authorized member, if the DPO is a limited liability company.

Printed name		Printed name	
Title		Title	
Signature		Signature	

Instructions

1. Within 3 months after the end of each fiscal year, complete and file this report for the preceding fiscal year with:

   The Office of Insurance Regulation
   Life & Health Financial Oversight
   200 E. Gaines Street
   Tallahassee, Florida 32399-0327

2. Provide all requested information on page 2. Have the report signed on page 2 consistent with the instructions thereon.

3. Answer questions a through r on pages 4 and 5, as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses, clearly identifying each attachment and the question number being answered.

4. Attach a copy of the audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding fiscal year.

   An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity. The Office may accept this petition if all of the following are met:

   - The licensee is 100% owned by the parent directly or indirectly
   - The parent receives an unqualified opinion
   - The parent's audited financial statement reflects at least a $5 million net worth on a GAAP basis
   - The parent provides a parental guarantee The licensee provides un-audited financial statement on a GAAP basis attested to which reflects a surplus of $150,000 or more.
   - Licensee requests petition in writing at least 30 days prior to due date of annual report

5. If different from the initial application or the last annual report, complete the schedule on page 7, and include the complete names, address, or Federal taxpayer identifying numbers, titles, and ownership percentages of all officers, directors, managing members, and 10% or greater owners, and for each indicate whether that individual is an officer, director, and/or owner. Please disclose the extent and nature of any contracts or arrangements between such persons and the DPO, including any possible conflicts of interest. Attach additional pages as needed.

6. For each individual who, during the period covered by this report, was a member of the DPO's Board of Directors, Board of Trustees, Executive Committee, or other governing board or committee, or who was one of its principal officers or managing members, responsible for the conduct of its affairs, or in a position to exercise control or influence over its affairs, **and for whom the DPO has not previously done so**, (1) make arrangements to have an investigation report forwarded directly to the Office, and (2) attach to this report: (a) a statement informing the Office of the date that such investigative report was requested, (b) completed NAIC Biographical Statement and Affidavit, and (c) two completed Florida fingerprint cards. Only Florida fingerprint cards will be accepted. Florida fingerprint cards may be obtained by calling the Office of Insurance Regulation, L&H Financial Oversight, at (850) 413-5052.

7. As stated in s.636.204(3), "The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of $50 and if the office is satisfied that the licensee is in compliance with this part." Attach evidence of your $50 renewal fee being paid to the Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100. Page 8 of this report should be detached and mailed to the address given, along with your check for $50, **prior to the anniversary date of the DPO obtaining its license**.

8. Answer the questions below as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses.

		Yes	**No**
a	Have there been any changes to any of the DPO's basic organizational documents, such as its bylaws or articles of incorporation? If so, attach an explanation of all such changes, and copies of the amended documents.		
b	Have there been any changes in the DPO's ownership? If so, attach a statement containing complete details, and an organizational chart depicting all direct and indirect relationships between the DPO and all of its affiliates, including the ultimate parent corporation of all such entities.		
c	Was the DPO a party to any civil or criminal legal action, other than as plaintiff in a civil matter? **If so, attach a statement containing complete details.**		
d	Is the DPO doing business in any state(s) other than Florida? If so, attach a schedule of all such state(s).		
e	Was the DPO's license, registration, or certificate of authority to act as a DPO suspended or revoked by any governmental agency, or did any governmental agency initiate formal legal proceedings for said purpose? **If so, attach a statement containing complete details.**		
f	Has any governmental entity imposed fines or costs, other than normal filing fees or renewal fees, for activities arising from DPO operations? **If yes, attach a statement containing complete details.**		

g	Has the DPO either maintained a surety bond in its own name, or securities eligible for deposit with Collateral Management, in an amount not less that $35,000?		
h	Are all advertisements, marketing materials, brochures, and discount cards used by marketers approved in writing for such use by the DPO?		
i	Does the DPO have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the DPO?		
j	Is the DPO monitoring the content of all its websites for compliance with s.636.210, s.636.212, and s.636.226 Florida Statutes?		
k	Did the DPO fail to pay any judgment rendered, if any, against it in any state within 60 days after the judgment became final? **If so, attach a statement containing complete details.**		
l	Was the DPO at any time unable to fully pay when due any debts, or to timely meet any other obligations: **If so, attach a statement containing complete details.**		
m	Was the DPO or any of its owners, officers, or directors, convicted of, or did it (or that person) enter a plea of guilty or nolo contendere to a felony in any state without regard to whether adjudication was withheld**? If so, attach a statement containing complete details.**		

		Florida
n	For the year covered by this report, what was the total amount of revenue collected for Florida DPO business?	$
o	How many residents of Florida are members of the DPO?	

p	List the internet websites used by the DPO and its marketers.

CHECK LIST

Please indicate by checking the boxes that each action has been taken

[_] This Report has been completed in its entirety with all schedules.

[_] Audited CPA financial statements and Opinion Letter are attached.

[_] Separate responses, cross-referenced to the question, are attached where appropriate.

[_] All financial statements and schedules are mathematically correct.

[_] If required, biographical statements, background investigative reports, and fingerprint cards

[_] Evidence of payment of license renewal fee.

[_] Requests for clarification may be sent electronically to the e-mail address below.

The person to contact regarding any information contained in this report is:

_____
(name & position / title)

_____
(address)

_____
(city, state, zip)

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ EXT: ___ ___ ___ ___ ___
(area code - telephone number - extension)

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
(area code - fax number)

_____
(e-mail, if applicable)

Name of Discount Plan Organization (DPO):

_____

Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____

MANAGEMENT / OWNERS INFORMATION

Provide the requested information for all new Officers, Directors, or Other Individuals Responsible for the Operations of the Licensee; include percentage of ownership in the % column. Also, provide the requested information for all new Owners (Members of the Licensee's Organization) with an interest of 10% or greater. If the new Owner is a company, partnership, or other organization, enter the requested information on the last line.

(See instruction 6 on page 3.)

	Name	Position/Title	Residence Address	FEIN	%

(If additional space is needed attach a separate sheet to this Schedule.)

For each of the individuals listed above, has the information required by item 5 of the instructions been included? _____

For each of the individuals listed above, are the attachments required by item 6 of the instructions been included? _____

Have all new officers, directors, and owners been revealed? _____

The following Officers and Directors are no longer associated with the DPO: _____
_____

The following, previously reported as having an ownership interest in the DPO, no longer have an ownership interest:

_____
_____

Office of Insurance Regulation
Life & Health Financial Oversight

REMITTANCE FORM

Detach and separately forward this page prior to the due date of the required license renewal with your payment to the address below.

Name of Discount Plan Organization	
Street address	
City, State, Zip	
Federal Employer Identification Number	__ __ -- __ __ __ __ __ __ __
Florida Company Code	__ __ __ __ __
Renewal Date of License	_____**2 0** __ __

ATTACH CHECK FOR $50.00 HERE.

MAKE CHECK PAYABLE TO
DEPARTMENT OF FINANCIAL SERVICES

MAIL PAYMENT & THIS PAGE TO:

DEPARTMENT OF FINANCIAL SERVICES
REVENUE PROCESSING SECTION
P. O. BOX 6100
TALLAHASSEE, FLORIDA 32314-6100

FOR OFFICE OF INSURANCE REGULATION USE ONLY

AMOUNT	TYPE/CLASS	FEE	FUND ACCOUNT
$50.00	1300	L	Renewal License Fee

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/industry_ucaa.htm, "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

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Final Approval to Adopt New Rules 69O-238.001,.002
Assignment # 224829-18

The Office of Insurance Regulation requests that these proposed new rules be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request for Final Approval to Adopt the proposed rules.

The notice of proposed rules was published on December 10, 2018, in Volume 44, No. 238, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

The Office of Insurance Regulation is developing new rules to implement Ch. 2018-91, Laws of Florida, signed into law on March 23, 2018. The legislation requires the Financial Services Commission to implement some of its provisions by rule.

Chapter 69O-238, F.A.C., will govern the regulation of Pharmacy Benefit Managers.

Section 624.490, F.S., is the rulemaking authority and laws implemented for these rules.

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

Michael Lawrence, Jr., is the attorney handling these rules. 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 69O-238
PHARMACY BENEFIT MANAGERS

69O-238.001 Application and Renewal.

(1) An applicant for initial registration as a pharmacy benefit manager shall submit the following:

(a) A nonrefundable fee of $5.00 made payable to the Florida Department of Financial Services along with a completed Form OIR-C1-2210, Registration Form for Pharmacy Benefit Managers Invoice, effective 01/19, hereby incorporated by reference and available at www.flrules.org/XXXXX. The applicant shall submit the nonrefundable fee and Form OIR-C1-2210 to the Department of Financial Services, Bureau of Financial Services, P. O. Box 6100, Tallahassee, Florida 32314-1600;

(b) A copy of the applicant's corporate charter, articles of incorporation, or other charter document submitted electronically via the Office's iApply system at https://www.floir.com/iportal; and

(c) A completed Form OIR-C1-2209, Registration Form for Pharmacy Benefit Managers, effective 01/19, hereby incorporated by reference and available at www.flrules.org/XXXXX, submitted electronically via the Office's iApply system at https://www.floir.com/iportal.

(2) Each registrant renewing its registration shall submit a nonrefundable fee of $5.00 made payable to the Florida Department of Financial Services along with a completed Form OIR-C1-2210 to the Department of Financial Services, Bureau of Financial Services, P. O. Box 6100, Tallahassee, Florida 32314-1600.

Rulemaking Authority 624.490(2), 624.490(6) FS. Law Implemented 624.490 FS. History-New .

69O-238.002 Change in Information.

Pursuant to section 624.490(3), F.S., if the information required by section 624.490(2), F.S., changes, the registrant shall file an amendment on the Form OIR-C1-2209, Registration Form for Pharmacy Benefit Managers, effective 01/19, hereby incorporated by reference and available at www.flrules.org/XXXXX, submitted electronically via the Office's iApply system at https://www.floir.com/iportal within 60 days after the change occurs.

Rulemaking Authority 624.490(3); 624.490(6). Law Implemented 624.490 FS. History-New .

Office of Insurance Regulation
Company Admissions

REGISTRATION FORM FOR PHARMACY BENEFIT MANAGERS

This package is designed to assist individuals in preparing the registration form with all the information required by statute and to facilitate expeditious processing of the registration by this Office.

The completed registration package must be submitted to the Office by utilizing the following link, unless otherwise specified herein:

http://www.floir.com/iportal
and select iApply – Online Company Admissions

Any questions concerning this application package may be directed to the Application Coordinator at appcoord@floir.com. For iApply only questions, contact the Application Coordinator at iapply@floir.com

In order for a submission to be considered a complete registration request, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

[Remainder of this page intentionally left blank]

Form OIR-C1-2209
Effective 01/19
Incorporated by Reference in Rules 69O-238.001 and 69O-238.002, F.A.C.

REGISTRATION FORM FOR PHARMACY BENEFIT MANAGERS

Name, address, and telephone number of individual to be contacted regarding this registration form:	
Name:	
Address:	
Telephone:	
E-Mail:	

SECTION A – Name and Address of the Registrant

Name of Proposed Pharmacy Benefit Manager:	

Address of the Proposed Pharmacy Benefit Manager:	

[Remainder of this page intentionally left blank]

REGISTRATION FORM FOR PHARMACY BENEFIT MANAGERS

SECTION B – Name, Address, and Official Position of Each Officer and Director

Name:	
Address:	
Official Position:	
Name:	
Address:	
Official Position:	
Name:	
Address:	
Official Position:	
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[Attach additional page if necessary]

REGISTRATION FOR PHARMACY BENEFIT MANAGERS

INVOICE

Registration is hereby requested as a Pharmacy Benefit Manager in accordance with the Insurance Laws of Florida.

Send the original check made payable to the Florida Department of Financial Services, and mail the check and invoice to the Department of Financial Services, Bureau of Financial Services, P. O. Box 6100, Tallahassee, Florida 32314-1600.

Attach a photocopy of the invoice and check for the amount of the required filing fee for the application being file. If sent electronically, redact the bank account number from the copy of the check for security purposes.

1. Name of Proposed Pharmacy Benefit Manager:

_____

2. Mailing Address:

_____

3. Federal Employer's I.D. No._____

Accounting Information

DRC	RSC	AMOUNT
C	1002F	$5.00

Form OIR-C1-2210
Effective 01/19
Incorporated by Reference in Rule 69O-238.001

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Final Approval to Adopt Amendments to
Rule 69O-137.001
Assignment # 227525-18

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request for Final Approval to Adopt the proposed rules.

The notice of proposed rules was published on December 10, 2018, in Volume 44, No. 238, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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. By adopting the current versions of these NAIC instructions and manuals, the Office is establishing up-to-date, uniform standards for annual and quarterly reports which will provide the information necessary for the Office to evaluate insurers' financial conditions.

Sections 624.308(1), 624.424(1), F.S., are the rulemaking authority and laws implemented for this rule.

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

Michael Lawrence, Jr., 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

69O-137.001 Annual and Quarterly Reporting Requirements.

(1) through (2) No change.

(3) Annual and Quarterly Statement Reporting.

(a) No change.

(b)1. The National Association of Insurance Commissioners electronic transmission filing instructions (Financial Internet Filing Online User's Guide 2018 ~~2017~~) are hereby adopted and incorporated by reference, www.flrules.org/XXXXX.

2. No change.

(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, 2017 ~~2016~~,

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 2017 ~~2016~~,

3. The NAIC's Annual Statement Instructions, Health, 2017 ~~2016~~,

4. The NAIC's Annual Statement Instructions, Title, 2017 ~~2016~~; and,

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2017 ~~2016~~.

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

1. The NAIC's Quarterly Statement Instructions, Property and Casualty, 2018 ~~2017~~,

2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health, 2018 ~~2017~~,

3. The NAIC's Quarterly Statement Instructions, Health, 2018 ~~2017~~,

4. The NAIC's Quarterly Statement Instructions, Title, 2018 ~~2017~~; and,

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2018 ~~2017~~.

(c) No change.

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

M E M O R A N D U M

DATE: February 4, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel
Sarah J. Berner, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 12, 2019
Request for Final Approval to Adopt Amendments to
Rule 69O-138.001
Assignment # 227526-18

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before March 6, 2019, and to the Financial Services Commission on March 12, 2019, with a request for Final Approval to Adopt the proposed rules.

The notice of proposed rules was published on December 10, 2018, in Volume 44, No. 238, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

These rules are being amended to adopt the 2017 and 2018 National Association of Insurance Commissioners Financial Condition Examiners Handbooks. The current rule adopted the 2016 and 2017 versions of these handbooks.

Sections 624.308(1), 624.316(1)(c), F.S., are the rulemaking authority and laws implemented for this rule.

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

Michael Lawrence, Jr., 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

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2018 ~~2017~~, is hereby adopted and incorporated by reference.

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

(2) through (3) No change.

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

QUARTERLY AGENCY ACHIEVEMENT REPORT

Second Quarter of FY 2018-19
(October-December 2018)

FLORIDA OFFICE OF
INSURANCE REGULATION

OIR IS RESPONSIBLE FOR REGULATING A **$153 BILLION** INDUSTRY.*

**Year End 2017 — Companies will begin filing 2018 financial information in March*

OIR works to make insurance more reliable, available, and affordable for Florida consumers, increasing market access, product options, and competition.

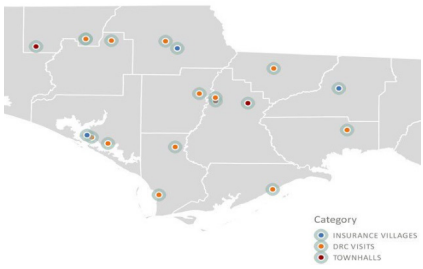
HURRICANE MICHAEL CLAIMS DATA

OIR initiated its catastrophe claims data reporting system immediately following Hurricane Michael. As of Feb. 22, 142,580 claims were filed with estimated insured losses of more than $5.8 billion. Of the claims filed, 77.5% were reported closed.

142,580
claims filed

77.5%
of claims reported closed

ASSISTING HURRICANE MICHAEL VICTIMS



Since Hurricane Michael made landfall, OIR has made more than 30 visits to various impacted communities to assist with the claims-filing process, ensure consumer needs are met, and identify challenges during the response and recovery process. OIR continues to focus on protecting consumers from AOB abuse.

ATTRACTING NEW BUSINESS

OIR has oversight of more than 4,300 entities. During the reporting period, 22 new entities entered the Florida insurance market.

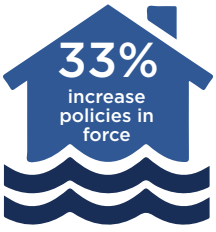
OPERATIONAL EFFICIENCIES

OIR has created the Insurance Regulation Filing System, for insurers and insurance-related entities to submit filings, forms, financial data, applications and other related content to OIR. This single point-of-entry filing system will make it easier for companies get products to market faster and conduct business in Florida more efficiently.

CONSUMER REFUNDS

OIR secured more than
$16 Million
in policyholder refunds during the reporting period.

FLOOD INSURANCE



Florida continues to be the largest, fastest growing private flood insurance market in the U.S., with more than 44,000 policies in force as of Sept. 1, 2018, which is a 33% increase over the prior reporting.

FLORIDA OFFICE OF INSURANCE REGULATION

David Altmaier, Commissioner
David.Altmaier@floir.com
(850) 413-5914